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APPENDIX

IN THE

Supreme Court of the United States

October Term, 1975

NO. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. and J. R., Minors, Individually and those representatives of a class of persons similarly situated,

Appellees.

APPEAL FROM THE JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

APPEAL DOCKETED MAY 21, 1976
JURISDICTION NOTED MAY 31, 1977

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IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA MACON DIVISION

J. L. and J. R., Minors, Individually and on behalf of all others similarly situated,

Plaintiffs,

v.

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources; W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health; W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Defendants.

RELEVANT DOCKET ENTRIES

1975

October 24, Complaint filed.

October 24, Motion for Preliminary Injunction, for Class Action and for the Convening of a Three-Judge Court filed.

October 24, ORDER, setting hearing for Thursday, October 30, 1975 at 5:00 P.M., in Macon, Georgia.

October 30, Hearing held before Judge Wilbur D. Owens, pursuant to the order issued October 24.

November 7, ORDER of Chief Judge John R. Brown, constituting Three-Judge Court, filed.

November 17, ORDER governing production of certain confidential documents of Central Georgia Regional Hospital, the Baldwin County Department of Family and Children Services, the Stephens County Department of Family and Children and the Department of Human Resources, filed.

November 18, ORDER confirming that the action was to be maintained as a class action filed.

November 19, Defenses and answer for all Defendants filed.

November 19, Affidavit of Janet Scott filed.

November 19, Revised Statement of Facts filed.

November 19, Stipulation of Facts for the district court hearing filed.

November 19, Hearing held by the district court.

November 21, Plaintiffs' Motion for Entry and Inspection filed.

November 21, ORDER of the district court granting Plaintiffs' Motion for Entry and Inspection filed.

December 2, Deposition of Eli Charles Messinger filed.

December 12, Depositions of Anne Etheridge and Nancy Autry filed.

December 12, Deposition of Dr. W. Douglas Skelton filed.

December 12, Deposition of Dr. James B. Craig filed.

December 15, Deposition of Arthur Falek filed.

December 19, Deposition of Daniel Offer filed.

December 19, Deposition of Dr. John Paton Filley filed.

December 19, Deposition of Walter Gove filed.

December 19, Deposition of Gladelle Whitaker filed.

December 19, Deposition of Martha Ann Taylor filed.

December 19, Deposition of Vivian Schoonmaker filed.

December 19, ORDER of the district court directing that all persons examining the record in this matter not disclose the names of the children involved except by Order of the Court, filed.

December 22, Received Supplemental Brief on Behalf of the Defendants together with Appendixes A, B, and C to Defendants' Supplemental Brief.

December 22, Stipulated Submission of Exhibits to Depositions filed.

December 22, Post-Discovery Memorandum of Plaintiffs received.

December 23, Deposition of Dr. Eugene C. Jarrett, III filed.

December 23, Deposition of Dr. Luciano L'Abate filed.

December 23, Deposition of Wladyslaw P. Mazur filed.

December 23, Deposition of Dr. Loren R. Mosher filed.

December 23, Depositions of Dr. Donald G. Miles and Dr. William Wieland filed.

December 23, Deposition of Hester Dixon filed.

December 23, Deposition of Dr. Everett C. Kuglar filed.

December 23, Depositions of Dr. John J. Gates and Dr. W. T. Smith filed.

December 23, Deposition of Dr. Lawson H. Bowling filed.

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

[1] [Filed at 10:50 A.M., Oct. 24, 1975,
Dorothy F. Motes, Deputy Clerk, U.S. District Court,
Middle District of Georgia]

J. L. and J.R., minors individually and on behalf of all others similarly situated,

Plaintiffs,

vs.

JAMES PARHAM, individually and as Commissioner of the Department of Human Resources;
DOUGLAS SKELTON, individually and as Director of the Division of Mental Health;
W. T. SMITH, individually and as Chief Medical Officer of Central State Hospital,

Defendants.

CIVIL ACTION NO. 75-163-MAC

COMPLAINT

Three-Judge Court
(Civil Rights Class Action)

I.

PRELIMINARY STATEMENT

1.

Plaintiffs, individually and on behalf of all others similarly situated, seek declaratory and injunctive relief, and damges, for violations of their civil rights resulting from the operation of Georgia Code §88-503.1(a). This statutory scheme permits parents and guardians of per-

sons younger than 18 years of age to cause the involuntary commitment of those persons to state mental health facilities under the guise of a "voluntary" admission statute. The statutory scheme conflicts with the due process clause of the Fourteenth Amendment to the United States Constitution in that it allows for the involuntary commitment of persons younger than 18 years of age: (1) without a hearing and other procedural safeguards and (2) without initial and periodic consideration of placement in the least drastic environment necessary for treatment. This cause of action, [2] arises under 42 U.S.C. §1983. Since these statutes are of state-wide application, a three-judge court is required.

II.

JURISDICTION

2.

Jurisdiction is conferred upon this Court by:

a. 28 U.S.C. §1343(3), relating to original jurisdiction under 42 U.S.C. §1983.

b. 28 U.S.C. §2201, §2202, relating to declaratory relief.

c. 28 U.S.C. §2281, §2284, relating to injunctive relief and three-judge courts.

III.

THREE-JUDGE COURT

3.

This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. §§2281 and 2284 since plaintiffs seek an injunction to restrain defendant state officers

from the enforcement, execution and operation of a state statute [Georgia Code §88-503.1(a)] of state-wide applicability on the ground that the statutory scheme is contrary to the United States Constitution.

IV.

PLAINTIFFS

4.

Plaintiff J. L. is a citizen of Georgia, age 12, who is being held against his will by the defendants or under their direction having been committed by his adoptive mother and stepfather pursuant to the challenged statute, Georgia Code §88-503.1(a).

5.

Plaintiff J. L. was committed without notice, hearing, right to counsel or order of a court.

[3] 6.

Plaintiff J. R. is a citizen of Georgia, age 12, who is being held against his will by the defendants or under their direction having been committed by the Stephens County Department of Family and Children Services pursuant to the challenged statute, Georgia Code §88-503.1(a).

7.

Plaintiff J. R. was committed without notice, hearing, right to counsel or order of a court.

V.

DEFENDANTS

8.

Defendant JAMES PARHAM is the Commissioner of the Department of Human Resources for the State of

Georgia. Pursuant to Acts 1972, pp. 1015, 1046 (Ga. Code §40-35101), defendant Parham has the responsibility to execute and administer all functions of the Department of Human Resources including the Division of Mental Health.

9.

Defendant DOUGLAS SKELTON is the Director of the Division of Mental Health and has direct administrative responsibility for controlling all mental hospitals under the Division of Mental Health.

10.

Defendant W. T. SMITH is the Chief Medical Officer of Central State Hospital and has direct administrative responsibility for the admission of persons to Central State Hospital.

VI.

CLASS ACTION

11.

The named plaintiffs bring this action on their own behalf and, pursuant to Rule 23(a), 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of all others similarly situated.

[4] 12.

The members of the class of plaintiffs similarly situated are all persons younger than eighteen years of age who have been, are, or may be committed by their parents or legal guardians to a state mental health facility under the direction and control of defendants Parham and Skelton pursuant to Georgia Code §88-503.1(a).

13.

The requirements of Rule 23 are met in that: the class is so numerous that joinder of all members is impractical

(and the knowledge of the total membership of the class is indeterminate); there are questions of law and fact common to the class; the claims of the representative parties are typical of the claims of the class; the representative parties will fairly and adequately protect the interests of the class; and the parties opposing the class have acted on grounds generally applicable to the class, thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole.

VII.

FACTUAL ALLEGATIONS

PLAINTIFF J. L.

14.

Plaintiff J. L. was committed to Central State Hospital on May 18, 1970, pursuant to Georgia Code §88-503.1(a). He was 7 years of age at the time of his commitment, and of normal intelligence.

15.

He was committed by his adoptive mother and stepfather, although he did not wish to enter the hospital then and does not wish to stay there now.

[5] 16.

At the time of his commitment, J. L. was not mentally ill and did not present an imminent likelihood of serious harm to himself or others.

17.

At the time of his commitment, J. L. was not afforded meaningful notice, a hearing, and other procedural safeguards to determine whether (1) he was mentally ill and presented an imminent likelihood of serious harm to him-

self or others, and (2) if hospitalization was the least drastic environment necessary for his treatment.

18.

J. L. was confined in Central State Hospital from May 18, 1970, through September 18, 1972, when he was released on furlough. Due to existing family tension, neither his adoptive mother nor his stepfather were able to meet J. L.'s needs and he was forced to return to the institution within ten days. He has been continuously confined since that date.

19.

In April, 1974, J. L.'s adoptive parents voluntarily relinquished their parental rights to Central State Hospital. J. L. has not seen his adoptive parents since that time.

20.

As a result of his inappropriate and unconstitutional institutionalization, J. L. has been and is being subjected to a regimented and standardized institutional routine which stifles his individual development and his opportunity to assume personal responsibility. He is forced to live with patients whose sometimes bizarre and frightening behaviors cannot be avoided. He has been subjected to a program of chemotherapy which has had and will continue to have long term detrimental physical and psychological effects on his development. His IQ has consistently [6] declined. He has developed allergies and respiratory problems and manifests deep feelings of insecurity, inadequacy, and hopelessness. He is stigmatized by the label of "mental patient" which has had profound reprecussions on his self-image and self-confidence and which will continue to influence, overtly or subtlely, the manner in which he will be treated the rest of his life.

21.

In the opinion of experienced and competent psychiatric personnel, J. L. is suffering from institutionalization and needs immediate placement in a less drastic environment.

22.

J. L. has not been afforded periodic consideration for placement in the least drastic environment.

23.

J. L. has not been placed in the least drastic environment.

24.

Although the defendants have known or should have known of J. L.'s inappropriate placement, J. L. remains incarcerated against his will at Central State Hospital.

PLAINTIFF J. R.

25.

Plaintiff J. R. was committed to Central State Hospital on June 24, 1970, pursuant to Georgia Code §88-503.1(a). He was 7 years of age at that time and was of average or slightly below average intelligence.

26.

After six placements in foster homes which, in each case, J. R. lost his place to a more favored child, he was committed by his legal guardian, the Stephens County Department of Family and Children Services (DFCS). DFCS had assumed custody on October 27, 1966, after the Juvenile Court of Stephens County had declared him to be a neglected child and removed him from his natural parents. J. R. has had no contact with either of his natural parents since his first foster placement.

[7]

27.

At the time of his commitment, J. R. did not wish to enter the hospital and does not wish to stay there now.

28.

At the time of his commitment, J. R. was not mentally ill and did not present an imminent likelihood of serious harm to himself or others.

29.

At the time of his commitment, J. R. was not afforded meaningful notice, a hearing, and other procedural safeguards to determine (1) whether he was mentally ill and presented an imminent likelihood of serious harm to himself or others, and (2) if hospitalization was the least drastic environment necessary for his treatment.

30.

In 1973, experienced and competent psychiatric personnel concluded that J. R. no longer needed to be confined at Central State Hospital and recommended that he be placed in a less drastic environment.

31.

J. R. has been continuously confined to Central State Hospital from June 24, 1970, through the date of the filing of this Complaint.

32.

J. R. is now 12 years old. He has had no contact outside the hospital for the last five years except for two to four temporary holiday visits to foster homes.

33.

As a result of his inappropriate and unconstitutional institutionalization, J. R. has been and is being subjected

[8]

to a regimented and standardized institutional routine which stifles his individual development and his opportunity to assume personal [8] responsibility. He is forced to live with patients whose sometimes bizarre and frightening behaviors cannot be avoided. More specifically as a result of the stress of his inappropriate and unconstitutional institutionalization, J. R. has been subjected to a program of chemotherapy which has had and will continue to have long term detrimental physical and psychological effects on his development. His IQ has declined. He is stigmatized by the label of "mental patient" which has had profound repercussions on his self-image and self-confidence and which will continue to influence, overtly or subtlely, the manner in which he will be treated the rest of his life.

34.

In the opinion of experienced and competent psychiatric personnel, J. R. is suffering from institutionalization and needs immediate placement in a less drastic environment.

35.

J. R. has not been afforded periodic consideration for placement in the least drastic environment.

36.

J. R. has not been placed in the least drastic environment.

37.

Although the defendants have known or should have known of J. R.'s inappropriate placement, J. R. remains incarcerated against his will at Central State Hospital.

VIII.

STATUTORY FRAMEWORK

38.

Georgia Code §88-503.1(a) provides as follows:

> The superintendent of any facility may receive for observation and diagnosis any individual 18 years of age, or older, making application therefor, any individual under 18 years of age for whom such application is made by his parent or guardian and any person legally adjudged to be incompetent [9] for whom such application is made by his guardian. If found to show evidence of mental illness and to be suitable for treatment at such facility and such person may be detained by such facility for such period and under such conditions as may be authorized by law.

39.

Pursuant to Georgia Code §88-503.1(a), a parent or guardian may "voluntarily" commit a juvenile to a state mental health facility regardless of a juvenile's opposition to admission. There is no provision in the Code for a hearing prior to admission to determine the appropriateness or necessity of such action. Nor is there anyone to protect the juvenile's interests in the admissions procedure. In effect, a juvenile is "powerless" to influence a decision which may result in his indefinite confinement in an institution.

40.

There is no statute, regulation, or policy which provides for periodic review and, where appropriate, placement in a less drastic environment, of juveniles committed pursuant to Geo gia Code Annotated §88-503.1(a).

IX.

FIRST CLAIM FOR RELIEF

41.

By operation of the statutory scheme, plaintiffs and their class have been, are, and will be involuntarily committed to and incarcerated in state mental health facilities without being afforded a meaningful and complete opportunity to be heard. Consequently, defendants have deprived them of liberty without procedural due process of law in violation of the Fourteenth Amendment to the United States Constitution.

42.

By incarcerating plaintiffs and their class without initial and periodic consideration of placement in the least drastic environment, defendants have denied them liberty without due process of law in violation of the Fourteenth Amendment to the United States Constitution.

[10] X.

SECOND CLAIM FOR RELIEF

43.

As a result of the deprivation of their constitutional rights, named plaintiffs have been damaged in the amount of $10,000.00 each.

XI.

INJURY

44.

As a result of their unconstitutional commitments, the plaintiffs and their class have suffered severe and irre-

parable injury, and have no adequate remedy at law to redress the stated constitutional deprivations and wrongs. Plaintiffs and the class they represent will continue to suffer irreparable harm from the constitutional deprivations and wrongs set forth herein unless and until the declaratory and injunctive relief sought herein is granted by this Court.

XII.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs, on behalf of themselves and the members of their class, pray that this Court:

1. Enter an order convening a three-judge court, pursuant to 28 U.S.C. §§2282 and 2284 to determine the controversy.

2. Enter an order certifying this action as a class action consisting of all persons younger than 18 years of age admitted by their parents or guardians to state mental health facilities pursuant to Ga. Code §88-503.1(a) as provided by Rule 23(c)(1) of the Federal Rules of Civil Procedure.

3. Issue a temporary restraining order stating that the defendants shall place plaintiffs J. L. and J. R. in the less drastic environment suitable to their individual needs.

[11]

4. Enter an order that the trial of this action on the First Claim for Relief shall be advanced and consolidated with the hearing on the motion for preliminary injunction pursuant to Rule 65(a)(2) of the Federal Rules of Civil Procedure.

5. Issue a preliminary and permanent injunction enjoining the defendants from:

a. enforcing and executing Georgia Code §88-503.1(a) as it allows the commitment of persons younger than 18 years of age admitted by their parents or guardians without due process safeguards provided by the Fourteenth Amendment to the United States Constitution

b. accepting into a state mental health facility any person whose admittance is sought by his parent or guardian on a voluntary basis unless such person has been afforded prior to commitment the right to:

1. meaningful notice;

2. a hearing;

3. counsel and, if indigent, appointment of counsel;

4. present evidence and testimony on their own behalf;

5. subpoena witnesses and documents;

6. confront and cross-examine witnesses against them and those who wish them to enter a facility;

7. independent expert examination and assistance;

8. have the defendants show by clear and convincing evidence that hospitalization is the least drastic environment necessary for treatment, safety and care;

[12]

9. be involuntarily hospitalized only upon a decision that they are mentally ill and present an imminent likelihood of serious harm to themselves or others, being based on clear and convincing evidence;

10. be involuntarily hospitalized only upon decision of a disinterested and impartial decision-maker;

11. appeal and review, including provision for assistance of counsel and record and transcript without cost if appellant is unable to pay the cost thereof;

12. other procedural safeguards.

c. failing to (1) immediately review the needs of each member of the class who is presently residing in the defentant's mental health facilities to determine their need for continued hospitalization and whether hospitalization is the least drastic environment for their treatment and (2) immediately place each member of the class in accordance with the findings of the review.

d. failing to (1) review the needs of each member of the class on a periodic basis and (2) immediately place each member of the class in accordance with the findings of each periodic review.

6. Enter a final judgment pursuant to 28 U.S.C. §§2201, 2202 and Rule 57 of the Federal Rules of Civil Procedure declaring that Georgia Code §88-503.1(a) is invalid, void and of no effect in that the statute violates the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution.

7. Award damages to plaintiffs J. L. and J. R. in the amount of $10,000.00 each for the unconstitutional deprivation of their civil rights.

[13]

8. Allow the plaintiffs their costs herein and reasonable attorneys' fees.

9. Grant such additional and alternative relief as may be deemed by this Court appropriate, just, proper and equitable.

Respectfully submitted,

/s/ DAVID GOREN
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[14]

GEORGIA, BIBB COUNTY

Personally appeared before the undersigned attesting officer, authorized to administer oaths under the laws of the State of Georgia, came affiant, who, after being first duly sworn, deposes and says that the facts and allegations set forth in the foregoing document are true and correct to the best of affiant's knowledge, information and belief.

/s/ DAVID GOREN
DAVID GOREN, GUARDIAN AD LITEM
FOR PLAINTIFFS

Sworn to and subscribed before me
this 24th day of October, 1975.

/s/ MILISSA H. WALKER
Notary Public, Georgia, State at Large

My Commission Expires:
August 24, 1979

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

[Filed at 10:50 A. M., Oct. 24, 1975, Dorothy F. Motes, Deputy Clerk, U. S. District Court, Middle District of Georgia]

MOTION FOR CLASS ACTION, CONVENING THREE-JUDGE COURT AND PRELIMINARY INJUNCTION

Plaintiffs J. L. and J. R. move the Court to grant the following relief:

1. Issue an order pursuant to Rule 23(c)(1) of the Federal Rules of Civil Procedure determining that this action may properly proceed as a class action pursuant to Rule 23(a), (b)(2) on the grounds that: the class, consisting of all persons younger than 18 years of age admitted to the defendants' mental health facilities upon the application of their parents or guardians, pursuant to Georgia Code §88-503.1(a), is so numerous that joinder of all members is impracticable; there are questions of law and fact common to the class; the claims of the representative parties are typical of the claims of the class; the representative parties will fairly and adequately protect the interests of the class; and the parties opposing the class has acted on grounds generally applicable to the class making appropriate final injunctive and declaratory relief with respect to the class as a whole.

2. Request the Chief Judge of the Circuit to convene a statutory court of three judges for the purpose of hear-

ing and determining this application for a preliminary and permanent injunction and this cause, in accordance with the provisions of Title 28 United States Code §§2281 and 2284 which require the [2] convening of such a court when an interlocutory and permanent injunction are sought to restrain a state officer from the enforcement of a state-wide statute that is alleged to conflict with the Constitution of the United States. The preliminary and permanent injunctions are sought to restrain the defendants, who are state officers, their successors in office, agents and employees, and all other persons in active concert and participation with them, from failing to provide to the plaintiffs and all persons similarly situated a meaningful hearing on their need for institutionalization and initial and periodic consideration for placement in the least drastic environment.

3. Issue a preliminary injunction pursuant to Rule 65 of the Federal Rules of Civil Procedure enjoining the defendants, their successors in office, agents and employees, and all other persons in active concert and participation with them from failing, pending a final decision on the merits, to give the plaintiffs and all persons similarly situated a meaningful hearing on their need for institutionalization and initial and periodic consideration for placement in the least drastic environment.

Plaintiffs seek this relief for themselves and all others similarly situated on the grounds that:

a. They and all others similarly situated are each suffering, or are imminently threatened with suffering, irreparable damage in that they have been or will be committed to the defendants' mental health facilities for an indefinite period without any meaningful procedural

and substantive safeguards to prevent inappropriate institutionalization;

b. The issuance of a preliminary injunction will not cause undue inconvenience or loss to the defendants but will prevent irreparable damage to the plaintiff and others similarly situated;

c. The statute [Georgia Code §§88-503.1(a)] that [3] deprives plaintiffs and all others similarly situated of their liberty violates the Fourteenth Amendment of the Constitution of the United States.

d. Plaintiffs have no adequate remedy at law, as set forth more fully in the verified complaint.

Respectfully submitted,

/s/ DAVID GOREN

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Attorneys for Plaintiffs

[1]

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION**

(Caption omitted in printing)

TESTIMONY OF DR. WAYNE HODGES

Given in Hearing before Judge Wilbur D. Owens, Jr.,
in Macon, Georgia, on October 30, 1975

DR. WAYNE HODGES

Witness called by the Plaintiffs, first being
duly sworn, testified on

DIRECT EXAMINATION

BY MR. GOREN:

Q Mr. Hodges, please state your name and address.

A Wayne Hodges, 548 Comanche Drive, Macon, Georgia.

Q Could you briefly describe for us your vocational work and training especially in regard to children?

A I have a B.S. degree in psychology from Troy State [2] University, and I have an academic degree, M.A. in general theoretical psychology from East Carolina University. I have a Psy. D., a Doctor of Psychology, from Baylor University in clinical child psychology concentration. Have been at Central State Hospital since '68. Primarily my experience there has been with children. Also much of my practical training period and my formal academic training was with children.

Q Have you published any articles?

A I have, about ten or twelve.

Q Have you published any articles in relation to children?

A Yes, I have. I think at last count twelve professional papers. I suppose about half of those must be directly related to treatment of emotional disorders in children.

Q Have you had any internship training?

A Yes, with Joseph (inaudible) University Medical School for a year, in Philadelphia, Pennsylvania, and there, by request, my concentration training was with children.

Q Is that a special internship program?

A Yes. It is an international program accepting certain quotas from the States and certain quotas from foreign countries who have practitioners interested in furthering their education in behavior therapy under Dr. Borpe (??) who is known in our profession as the father of behavior therapy.

[3]

Q Doctor, could you please describe for us in general the effects of immediate and long term of inappropriate hospitalization of children.

A Well, the immediate effects seem to have to do with depersonalization and desocialization of persons thrown into these types of settings. I suppose I could narrow it down to generalities somewhat when I say these types of settings to pertain mostly to the State Hospital type of setting. Immediately there is the depersonalization that takes place, and some sort of conditioned emotional

responses that frequently occur from frustrations they are undergoing. There seems to be a period of time in which individuals may be exposed to inappropriate learning experiences so that by modeling he may adopt many of the other patients inappropriate behavior to his own repetoire, primarily due to a lack of alternatives given to him in his development to cope with stress. He readily takes on those behavior patterns that he sees as being a viable alternative for himself. Reaching a little further in terms of scope into the future, we find two sub-groups of patients that usually evolve due to institutionalization. I base my opinion at this time primarily on the work of Gogden and if I am not mistaken a fellow named Base has also done some work in therapy, but it's been a long time since college exams, so the names may not be exact. But he has found that the two groups are those [4] patients who tend to become colonized and then those patients who tend to organize to try to beat the system. The colonization of patients seems to be the one resulting in the most detriment to the patient, since they essentially become a very dependent species, unable to take care of themselves independently in the regular mainstream of life.

Q Do these effects become more pronounced as the state in the hospital progresses?

A If you mean more pronounced in terms of their prognosis, yes. Although of course the height or intensity of the maladaptive behavior of course may not go beyond that after a certain number of years. But in terms of the increase of the—in terms of the prognosis, continuance of hospitalization will make the prognosis progressively poor because tendencies grow with time and with practice and a very strong habit that's maladaptive will be much more difficult to treat, and will have far-reaching effects

in terms of any intervention that you might try with the patient. I might add that all of these factors allow for the original behavior of the person and the original disorder they first presented themself with to sort of multiply and intertwine so that as previously I have stated at one time, they became somewhat panicled with the original problem and solving the thing becomes rather difficult.

Q Are these effects more exaggerated when dealing with [5] children as opposed to adults?

A In terms of prognosis I would say certainly, because you see with adults much of our treatment has to do with the breaking down of inappropriate behavior, and then attempting to instill an alternative. With children, due to age, and due to familial reasons due to environmental reasons, they never actually develop the behavior and appropriate responses in the first place, so that they are highly susceptible to implementation of much behavior that otherwise they would not have, since they are in a learning process, so that treatment then becomes not only one of breaking down—it also becomes one of instilling and giving alternatives, so that it is a two-fold process with children. Then if appropriate treatment isn't given, by the time that child spends a great deal of time in such an environment in an institution, we may find that the process of breaking down is very difficult because he has had time to model from a myriad of behaviors, and we may find the process of giving alternatives to be very difficult because he has ingrained a great many mutually exclusive inappropriate behaviors that work against any therapeutic behaviors that we try.

Q Would you describe your present job and your duties and responsibilities in that job?

A Theoretically I am clinical director of psychology. I am also—in terms of duties—this has to do with monitoring [6] and carrying on all functions of professional psychology.

Q Is that at Central State Hospital?

A Yes. There is a more recent name for it—Central Georgia Regional Mental Health Center. Then I have teamly functions, which—on the girls ward—which essentially a synthesized function of all ward activities and serve as consultant to attendant staff and so forth in dealing with patients and to assist the ward physician with planning and disposition of patients, and as conceived is mainly an active day to day on the ward monitoring and intimate involvement with all patient activities, intake, treatment, disposition, and so forth. In terms of job title, I suppose this is it. I am also involved in various other activities.

Q Doctor, are you familiar with a study done in 1973 on Central State Hospital's facilities for children and adolescents?

A Cursorily.

Q What I would like to do, Doctor, is to retrieve from that study their recommendations, conclusions, and see if you agree with it in regards to the facilities at Central State Hospital. Recommendation A—there are not adequate facilities to serve the present need at Central State, therefore it is essential that the new regional hospitals begin child services as soon as possible, and children at Central State from geographical areas having hospital [7]services be transferred.

A Yes, I am familiar with that.

Q Do you agree with the statement?

A Is that the No. A? Yes, I agree.

Q The second statement—

THE COURT: Mr. Goren, wouldn't it be appropriate to first, for the Court's information, remembering that the Court known nothing about the facilities, just to give us a basic description of the physical facilities over there for children? You may not want to do it with him, but that's something the Court needs to know, to be able to understand anything about the problem.

MR. GOREN: O.K. What we will do, Your Honor, is ask Dr. Hodges to explain his agreement with these conclusions in regard to the specific facilities at Central State.

THE COURT: All right. Just bear that in mind.

Q Mr. Goren: Dr. Hodges, the second of the conclusionary recommendations is that plans should begin now for closing the 80-bed adolescent unit, as a physical facility completely unacceptable for therapeutic rehabilitation for young children.

MS. KIRKLEY: Your Honor, I object to his [8]answer that until he has laid the foundation showing that he knows that facility—

THE COURT: Doctor, are you familiar with the 80-bed facility in question?

THE WITNESS: Are you talking about the C & A unit?

MR. GOREN: Yes sir, the adolescent unit.

THE WITNESS: Yes sir.

THE COURT: All right. Let him describe the unit.

Q Mr. Goren: Dr. Hodges, explain why you are familiar with that unit and your description of that unit, please.

A Well, administratively I am not familiar with the ins and outs of it. But in terms of the physical plan and at least the low level of administration, I am familiar with it. We have part of the Boland Building which is one of the older buildings, for the adolescents, and I don't know how many beds we actually have in those. The childrens building is a new building and very nice in terms of physical accomodations as it now stands and as it now functions, and that is primarily for the treatment of children. The adolescents and children are separated.

THE COURT: What's the difference in an adolescent and a child as you use that term?

[9]

THE WITNESS: Your Honor, could you be a little more specific?

THE COURT: You differentiate between children and adolescents.

THE WITNESS: In the sense that I use it?

THE COURT: Yes sir.

THE WITNESS: I think over 12 years—I think I should answer that not from a professional viewpoint but from the viewpoint of how the C & A unit is run. 13 and up are considered adolescents and are placed in the adolescent ward, and those below that age, children.

THE COURT: Doctor, go back and give me a basic description of the buildings where these children are housed—are they housed in one room, or in separate rooms, or how?

THE WITNESS: O.K. In the adolescent unit the male and female wards are separated by a lobby. Within the ward itself there is separation by a metal gate into two different areas. There is common bedroom facilities for the in patients. The beds are in sort of, I suppose, a Belaire arrangement in terms of having no partitions between them—sort of open.

THE COURT: Are they cots, or double deckers?

THE WITNESS: They are Army bunk type beds [10]—not bunk beds one on top of the other, but they are individual beds, maybe a little bit less than twin size—they remind me of Army barracks type of bed. Then outside of the bed area there is a sort of day room area which essentially is probably a 30 x 10 feet area in size, in which there is TV and couches along the wall for them to collectively spend their day if they choose to watch TV and to interact in that way. It's a flat roof structure, the walls are fairly well painted right now, have various posters on them for cheering up the guys, and there are—there is one doctor's office there on the ward which is toward the far end of the ward, near the outside lobby. The secretary is away from that office so that work can be done, due to the noise from TV and activities of the patients if they are near the office area. It's tile floor. In the center of this complex I have just described is a nurses' station which attending ward personnel house their administrative functions.

Q Mr. Goren: Doctor, could you now explain why these facilities lead you to agree with the conclusion which I read earlier?

MS. KIRKLEY: Excuse me. I believe he just described the adolescent unit.

THE WITNESS: Yes, I did.

[11]

MS. KIRKLEY: And did not describe the children's unit.

THE COURT: Describe that also.

THE WITNESS: The children's building is separated also. The entire building is split in a sense down the middle, and separates male from female sides. The interior there reminds me very much of a dormitory life sort of setting. There is a sort of bright atmosphere as compared to the adolescent ward—lots of bulletin boards. It is a new building and it's well kept and there's lots of activity going on there professionally, activity such as music therapy, and the kids can wander in there occasionally which I have seen them do. The sleeping area seems to be recognized as dormitory like. Again they have more privacy in that the sleeping area if I recall correctly is divided off into separate rooms.

Q Mr. Goren: Doctor, have you had an opportunity to examine and review the case records of plaintiff J. R.?

A Yes.

Q First of all, what unit is J. R. in?

A Adolescent 7.

Q That was the first unit you described?

A Yes.

Q And based on your examination and your review of [12] J. R.'s case history, have you been able to form an opinion as to his need for further hospitalization?

A Yes. I would like to state as I have previously that I am not familiar with the record in every exacting detail.

I have reviewed the record and followed it in sort of a chronological order and was able to form a diagnostic impression, an impression of what disposition would be most appropriate. But I don't want to purvey the idea that I have an infallibility, an infallible intimacy with his record. Would you please repeat the question?

Q Have you also personally examined J. R.?

A Yes. Well, I saw him for about 15 to 20 minutes interview.

Q Based on that interview and perusal of the record which you just described, were you able to form an opinion as to his need for further hospitalization?

A Yes. Also I talked with the team leader from his ward area who has a very close working knowledge of the boy. This constitutes partially the basis for my opinion. I feel like that J. R. is just a mildly retarded individual who needs structure and supervision but could function much better in a setting characterized by a heck of a lot less structure, and that would afford him more appropriate opportunities for him to develop his self-supporting skills as he grows older.

[13]

Q Would continued hospitalization of J. R. be harmful to him?

A I believe that it would, for the reasons that I stated earlier. A boy this age is easily led and with his limitation in ability he would be as highly susceptible to suggestion, who also—many kids who have a history like this also in a sense are affection hungry so that they will do things for mere peer attention and pure acceptance. So that what I am saying overall is that it would be fairly easy for them to incorporate a great many inappropriate behavior to his

own repetoire, that would lead us to characterizing him as being pretty maladjusted, plus, as I mentioned earlier, the habit strength of these individuals increase with each day, just making it more difficult to ever break them down and instill new behaviors. The third consideration is that this type of child is an excellent type of candidate for colonization, as I earlier explained as being taken from Gogden's research.

Q Colonization being what?

A Colonization being development of very dependent type personality, one that is "a good patient" and looks to ward life structure and guidance for his existence from minute to minute and cannot function independently from the ward structure, and in patient hospital structure. They are institutionalized is also another term frequently used to describe this type of patient.

[14]

Q You are saying that each day he is there he is susceptible to becoming more institutionalized and therefore will have lesser of a chance of succeeding on the outside?

A Yes.

Q Do you have a recommendation for what alternative placement would be appropriate for J. R.?

A Well, this is a very difficult question, because it has to do with the alternatives available. So that while one could certainly say the present setting is not the optimal one and in many respects could be detrimental, it's not easy to put your finger on what would be most appropriate. I am also impaired somewhat by my lack of knowledge in toto of what Georgia offers. I will try to answer your question after all this qualification. A specialized foster home setting could possibly do it. A smaller group home setting, such as a Boys Ranch where he would get structure and some objectives from day to day, something to do with guys, maybe work pretty hard during the week, with lots of interaction and stimulation, maybe fishing on the weekend, a camping trip, or something like this—a much less structured and more healthy optimistic type thing.

Q Now back to Plaintiff J. L.—

THE COURT: Before you leave J. R., what do you mean by slight mental retardation?

THE WITNESS: A mild retardation. This is [15] characterized by a deficiency in scope and skills and intelligence level is somewhere around 65 to 75. These kind of people usually are—they are not stupid, but they are rather slow. They make good solid citizens. They work hard, see after their own business, like to go to town on Saturday afternoon to a movie, but they never pursue academic skills. They just are people who can function, not very brightly, but nevertheless they are not severely impaired.

THE COURT: Let me ask you—from your review of his record, do you perceive that had he existed in a normal parental situation that he could have survived in the public school system of this State? If he had caring parents who sent him to school like everybody else does?

THE WITNESS: I believe not without special resources—resource teachers or special education classes.

Q Mr. Goren: One more thing about J. R. This function that you just described for people who are the same level of retardation that J. R. is presently at, would his continued hospitalization harm his chances of being

able to fulfill his potentials for somebody of his intellectual capacity?

A Yes, for that reason, that is the intelligence reason. [16] And of course for other reasons whethera person is mildly impaired or not, their behavior is determined not only by an inherent or low I.Q. level but by the opportunities afforded them. We have indication that not only is it a matter of having opportunities afforded, but if they do not occur at a certain time and in a certain way then the person may be permanently impaired from incorporating this into day to day functions. In other words, if a person doesn't learn how to learn sometimes, they can't even learn later even though they normally would—so that you may have instilled sometimes a situation whereby a person's ability to further incorporate is harmed.

THE COURT: Doctor, what do you perceive other than the slight mental retardation to be the cause for this child being kept in this facility, Central State Hospital, during the time he has been there?

THE WITNESS: I think primarily a lack of alternatives for more appropriate treatment. I think that is the primary reason.

THE COURT: Are you saying that from your review of the record that you gather that the State just had no place else to put this child?

THE WITNESS: I wouldn't say that they had no other place, but apparently it seemed to the people involved in the case at the time that this was the most [17] suitable alternative that they had to offer.

Q Mr. Goren: Doctor, have you also had an opportunity to examine J. L. and review his record?

A Yes.

Q And what ward is he on?

A He is on the male side of the children's unit.

Q Have you had an opportunity to form an opinion as to his need for further hospitalization?

A Yes.

Q What is that opinion?

A I believe more suitable arrangements could be made, possibly specialized foster care situation. It must be understood that frequent professional treatment should be carried out by the prospective foster parents for a more optimistic future there would need to be counseling continued.

Q What would be the effect on J. L. if he were required to remain hospitalized?

A It's my opinion that with this particular boy he seems to have a little get up and go about him. I don't think that he would become colonized. I think he would become one who would attempt to beat the system and would become very hostile, aggressive, and begin to show his displeasure and aggravation by a large number of responses that could make him be sort of obnoxious. Particularly a kid with his intelligence level and knows what's going on, there will [18] be an increased tolerance threshold so that you begin to see additional emotional responses occur that add to the problem, the additional emotional responses being simply a generalized emotion—a sort of frustration situation, and they may become sort of patterned or attached to various functions socially and so forth so that they come out and become visibly as part of the psychological problem.

MR. GOREN: I have no further questions.

THE COURT: What do you perceive to be the reason for J. L.'s being admitted and being kept in this facility?

THE WITNESS: I guess it would be kind of like what we had on the other—lack of alternatives. What do you do, if we put ourselves in the place of the individuals who are dealing with the child at the time. The familial situation was unstable, there was a traumatic point and the child had reacted to this with a good deal of frustration, irritability, hyperactivity, the school couldn't handle him, the family couldn't handle him, and no one wanted him.

THE COURT: He is just seven?

THE WITNESS: Yes. It's not unusual to see hyperactive reaction in children exposed to a traumatic situation.

THE COURT: What—I know what I think that [19] term means, but how do you use that term?

THE WITNESS: Well, the child is usually one who has a very short attention span, won't pay much attention to anything for an appreciable period of time. He is eternally from one thing to another. He is easily upset and aggravated. You can't get him to settle down, he's hard-headed, won't listen to you.

THE COURT: Sounds like my four-year old.

THE WITNESS: I could put that into other language, but I feel like that describes it as much as anything else.

THE COURT: Do you consider that to be an abnormal trait of children at 7 years of age?

THE WITNESS: To the degree it was being shown, it was abnormal when you compare it to normalcy. When you go to talking about abnormality, there are five different ways pathologists characterize this term. In the sense that you just mentioned it, you are speaking in reference to a known. That is, how does this child's behavior compare to an average. If we look at it in that sense, I think possibly we would have to say that his behavior exceeded the intensity and amplitude of those kinds of behaviors seen in normal people. If you look at it from the sense that is the behavior abnormal given the circumstances in which it evolved, I [20] would say no, it is quite normal behavior for child of that age to display given the situation.

THE COURT: And what do you perceive to be the mental level of J. L.?

THE WITNESS: How smart he is, Your Honor?

THE COURT: Yes.

THE WITNESS: He is average intelligence.

MR. GOREN: Just a few more questions, Doctor.

Q Mr. Goren: In children who are admitted to the hospital, do you often find that there is stress within their family situation?

A Would you remind repeating that?

Q Children like J. L. who are admitted to the hospital, do you often find in the history of children like this that they come from a stressful family situation?

A Yes. Very much.

Q Does that often lead to their hospitalization?

A Yes. I think that implied in this kind of question you are asking is something that has been battered about for years in our field, and that is—well, I will just give a conclusion. It's now inconceivable that we could try to determine the abnormality in the absence of considering the situation in which it occurred. You say is there a stressful family situation associated—well, there must be [21] some situation associated because little has been done in the science of psychology sans disorders directly connected to some physiological or organic basis. Then we must always, at least from my viewpoint, consider that a disorder can develop in the sense of some learning process by some pathological lesion forming, by a constitution which it itself can also be involved. And the third way is by learning, which is by far the biggest reason for our behavior.

Q To treat children who come from that kind of family situation, is it necessary also to work with the family?

A Yes.

Q And what would be the effect if there wasn't any family to work with?

A The question you always ask in the treatment of a child in your consideration of when he should go back, when should he be entered back into the community, is how many of the relevant precipitating elements were altered by the treatment. If none have been altered, and if the behavior had its beginning in this situation, and you haven't altered any of the elements, you almost have to predict that the same thing is going to occur.

THE COURT: Doctor, in what proximity are the physical facilities that you described to the adult facilities? Physical proximity.

THE WITNESS: Judge, I would say a half to [22] three-quarters of a mile.

THECOURT: From the nearest facility?

THE WITNESS: I believe that's right.

THE COURT: What opportunity is there for the children to get outside the building you described and onto the grounds?

THE WITNESS: They do have activity therapy and they are given opportunity to go out on a daily basis. This is determined partly by the particular problem of the individual and the amount of ward help available for monitoring the children. But at least as it is set up all of them have opportunity to go out if their behavior and the circumstances let them go out.

THE COURT: Is there any type schooling?

THE WITNESS: Yes sir. There is a special education school that is directly connected with the hospital and is actually in the same building with the adolescent unit.

THE COURT: All right.

CROSS EXAMINATION

BY MR. LACKEY:

Q Doctor, without being unduly repetitious, I would like to begin again with the physical facilities, if I might. It is true that J. L. is located in the children's facility at this time, isn't it?

[23]

A Sir?

Q It is true that J. L. is located in the children's facility at this time, isn't he?

A Yes, that's right.

Q And that J. R. is located in the adolescent facility?

A Yes, that's right.

Q Let's talk about the children's facility. You used the term dormitory, school dormitory.

A Yes.

Q Is it departmentalized?

A Yes, it is.

Q And you say there's always activity going on there?

A Yes, I think that's fair to say.

Q Is there a professional staff available there in that facility?

A Yes, there is.

Q What type of staff—just very briefly.

A We have attendants, nursing personnel, activity therapists are available from time to time, there is a psychology staff there for contact with the patients.

Q In other words there is a full range of psychiatric services there?

A Yes.

Q From psychiatrists on down to attendants?

A Yes. If you would like to use that ladder.

[24]

Q Just going through the range, from people who are there the most to people who are there the least. There are play areas for the children at this facility, aren't there?

A Play areas?

Q Play areas—entertainment areas.

A Yes.

Q There are recreation facilities available to them. Swing sets and that sort of thing?

A Yes sir, they've even got an old hook and ladder from an antiquated fire engine.

Q Now in the adolescent unit—by the way, do you know how many children are in the children's unit today?

A I am not able to answer that. It's under 20 and maybe over 10.

Q Let me break that down. Under 20—does that include male and female?

A I believe that's right.

Q And they are separated by sex?

A Yes.

Q So that means that following normal percentages there are probably 10 male children and 10 female children?

A Yes.

Q So the males interact in a group of 10 and the females in a group of 10?

[25]

A Yes. Like I say, I can't be specific.

Q And they have a school right there in the building?

A From the children's building the school is just a short walk. Yes.

Q There is a school available.

A Yes.

Q Are they required to attend and perform to their abilities?

A Yes.

Q Is this a highly specialized school?

A It is a special education school and offers a curriculum to my knowledge fairly representative of special education schools. I don't know really how to respond to that.

Q Are these special education type schools available everywhere in the State, to your knowledge?

A To my knowledge they are.

Q The way you answered that is that that you don't know, or—

A That probably would be the best answer. My wife is a teacher, we've been all over, I guess. Most schools have special education, and I think this is sort of set up by legislation and governed by the educational system.

Q You spoke of models when you were discussing some of the problems of children. Do the male staff members act as models for the children under normal circumstances?

[26]

A If you mean by models in the form of therapeutic sense I would say no. Of course any live person is a model whether it is by intent or whether it be inadvertent.

Q And one more question about the children—are they fed regularly three meals a day, this sort of thing?

A To my knowledge they are. They all seem to look healthy.

Q Let's talk about the adolescents. The physical layout as I understood it, in this case there are different wings for the males and females?

A Yes.

Q And as I understood you, each wing is again divided in at least two sections?

A Yes.

Q How many children would you presently say are in the adolescent building?

A Male and female?

Q Yes.

A I would say close to 40—give or take 2 or 3.

Q And again using the normal percentages I would say there are approximately 20 males and 20 females?

A Yes.

Q And the wards are divided—I assume they are separated into even smaller groups again?

A Depending on how things are going. They may be and [27] may not be, but they have that potential.

Q They could be divided—assuming they were divided equally, there would be 10 in one group and 10 in the other?

A Yes.

Q Do they have recreational facilities available in the adolescent ward? I know you described the place, but I am more interested in the outdoor type—

A Yes, there is—the building is constructed so that in the physical layout of it, the building is such that there is a

quadrangle enclosed, in the building itself. They get out in there. I must say the recreational facilities as I described for the children I think are probably more adequate than they are for the teenagers, because here you have a different set of needs for recreation, and I must say that the physical facilities for their recreation is not that good. We do have activity therapy and we have recently added occupational therapy.

Q Do you have therapists who deal with music?

A Yes.

Q What other kind of therapists do you have available?

A There is recreational therapists.

Q Are all these therapists—

A And there is occupational therapy, which is servicing a very limited number of the patients.

Q There are for these adolescents various types of [28] therapy available and for the children also?

A Yes. There is. There is some amount—but I don't feel competent saying at this time that it is adequate.

Q The point I am getting to, Doctor, and that I am trying to make to the Court is that we are not keeping them caged over at the Central State Hospital, each in his own little place, with no stimulants or anything else, are we? We are providing some sort of services?

A Yes.

Q There is professional help provided?

A We make every effort for that to be so. In some cases that is not possible.

Q Now let's talk about your diagnosis—let's go back—you gave us quite an impressive list of credentials. When did you finish your formal training in this area?

A August 16, this year.

Q August 16 of this year? Is that when you rejoined the hospital on a full time basis?

A Yes.

Q So you just in essence finished your formal education?

A Yes.

Q And embarked on your professional career. Is that the case?

A Yes.

[29]

Q And did I understand you to say that you had—

MR. LACKEY: Your Honor, is it appropriate for me to use the first names of these children? We've been doing that all day.

THE COURT: I think so. Yes.

Q Mr. Lackey: It's my understanding from our conversation earlier in which you testified today that you had seen Jimmy for approximately 20 minutes.

A Yes.

Q And for Joey you had seen him approximately 20 minutes in an interview situation and on other occasions in a perfunctory manner. Is that correct?

A That's right.

Q So in essence, I take it,—and you also read the files on the two boys?

A Yes.

Q Now isn't it true then that basically what you told us all today is based on not your study of these two cases but on your general theory of how children should be handled—children with emotional problems should be handled?

A No sir, I don't feel that is is. I also would like to add to the two aspects that formed the basis, and that is my third point that I talked with a member of the psychology staff in the children's unit about J. L. to add to my readings. I also talked with the team leader on adolescent 7 about [30] J. R. to supplement my reading, so that not a great deal existed on the theoretical level. I do have to say I based it on the basis of my professional opinion.

Q In that case what you must be saying is that there are children there that you think should remain in that institutionalized situation?

A Yes sir.

Q Are you familiar with the social background of these two children from your review of the record?

A Not in great detail. I am in terms of the sort of unstableness of the situation—this type of thing, and I know I would be very vulnerable to questions or specifics in that area.

Q I take it then you are not aware that J. R. has been sent to a foster care type situation at least nine times or ten times since he was originally brought to Central State Hospital?

A I was not aware of that.

Q Let's talk about your diagnosis again—you diagnosed one of the children as being mildly retarded. Doesn't the case record indicate that this child also had emotional

problems, throws temper tantrums, head-banging, bed-wetting?

A Yes.

Q Aren't those all symptoms of some sort of emotional [31] disorder?

A Yes, they are.

Q Something besides mental retardation?

A Yes.

THE COURT: Head-banging and bed-wetting are symptoms of what?

THE WITNESS: As the lawyer said, of further emotional disorder, if it's intense enough, and I assume that he mentioned that in that context—

MR. LACKEY: I was reviewing the record where it was reported that he threw temper tantrums, head-banging, bed-wetting, this sort of thing.

THE WITNESS: And your question was are these sometimes symptoms of other emotional disorders. Was that your question?

MR. LACKEY: Yes.

A The Witness: Yes, these are sometimes symptoms of other emotional disorders, particularly with emphasis on the intensity.

THE COURT: They are also symptoms of a normal child, aren't they?

THE WITNESS: That's true.

THE COURT: I have known of many children that do the same thing—normal children that live up and down the street.

[32]

MR. LACKEY: In his medical records these were given as part of the reason at the time of his admission.

THE COURT: That's what's disturbing to the Court.

MR. LACKEY: Well, the Doctor has said this demonstrates some emotional disorder.

THE WITNESS: I said sometimes. Let me talk for a minute if I may, about the problems of diagnoses.

THE COURT: Let's don't do that. Go ahead.

Q Mr. Lackey: You mentioned you thought the idea for these people would be specialized foster care? Is that correct?

A For J. R. I think I said either that or a group home setting with sort of a more optimistic atmosphere, such as a Boys Ranch.

Q Just assume for the moment that a Boys Ranch is available—I don't know that it is—what is different—as I understand it, a Boys Ranch type situation is again a group setting of a number of persons who are in a ranch type setting. They are still in a group, and I assume that the group would be no smaller than the ten we are talking about here. What makes that situation any more different so as to warrant setting up a special system?

[33]

A I have to speak from my experience and my context of what is a Boys Ranch, at least from my understanding, it's based on a home type existence in which the kids are not depersonalized in that they can have their own personal items, they have their own beds in a rather private area. They can more or less go and come at will, but they have specific tasks.

Q I take it you mean then out of the professional setting—by home setting you mean a typical foster care setting with just ordinary people running the situation for the child as opposed to a psychologist or social worker or something like that?

A Yes.

Q You are not talking about the professionals that we can go out and hire on the street?

A No.

Q You are talking about somebody who really cares about kids and wants to do something for them?

A Yes.

Q Do you know where the is a list—where there is a group of people like that that we can draw?

A No.

Q Isn't it the same way with specialized foster homes? Isn't the main ingredient the people—the person, the foster parents?

[34]

A Yes. And there are hardly any homes available, particularly for this age group.

Q And that isn't something money can cure, is it?

A Well, I think it probably is, because it seems that the level of values is very very intimately associated with social economic power.

Q You mean if the Judge raises the anti high enough we will find some of this parential love out there?

A I think it would flourish.

Q Is that what you want for the children? That kind of parental love?

THE COURT: Well, that—let's get off that.

MR. LACKEY: No further questions, Your Honor.

REDIRECT EXAMINATION

BY MR. GOREN:

Q Would the behavior of these children deteriorate if they remain hospitalized?

THE COURT: I think he has already answered that question. In his opinion continued hospitalization would be detrimental.

MR. GOREN: That's all.

* * * * *

[1]

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA MACON DIVISION

(Caption omitted in printing)

[1] [Filed at 9:30 A. M., Nov. 18, 1975, Dorothy F. Motes, Deputy Clerk, U. S. District Court, Middle District of Georgia]

O R D E R

This confirms the court's verbal order of October 30, 1975, pursuant to Rule 23, Federal Rules of Civil Procedure, that this action is to be maintained as a class action. The class consists of all persons younger than 18 years of age now or hereafter received by any defendant for observation and diagnois and/or detained for care and treatment at any "facility" within the State of Georgia pursuant to 1969 Georgia Laws page 505, 517, informally codified as 1933 Georgia Code Annotated § 88-503.1. The representatives of the class are "J.L." and "J.R." by their guardian ad litem David Goren, Esquire. The present basis for this action so proceeding is Rule 23(b)(2). This order is conditional and may be altered or amended before a decision on the merits.

SO ORDERED, this the 17th day of November, 1975.

/s/ WILBUR D. OWENS, JR.

WILBUR D. OWENS, JR.
United States District Judge

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

[1]

DEFENSES AND ANSWER

COME NOW all defendants and make the following defenses and answers to Plaintiffs' complaint.

DEFENSES OF LAW

1.

The Complaint fails to state a claim upon which injunctive or declaratory relief may be granted.

2.

The Complaint fails to state a claim upon which monetary relief may be granted.

[2]

ANSWER

Responding to the specific allegations of the Complaint, the defendant show the following:

1.

Defendants admit that plaintiff seeks declaratory and injunctive relief, and damages for violation of their civil rights resulting from the operation of Ga. Code § 88-503.1. Defendants also admit that the cause of action arises under 42 U.S.C. § 1983 and that since an injunction of a statewide statute is requested that a three judge court is required. Defendants deny the remaining allegations of paragraph one (1) of the Complaint.

2.

The allegations of paragraph two (2) of the Complaint are admitted.

3.

The allegations of paragraph three (3) of the Complaint are admitted.

4.

Defendants admit that plaintiff J.L. is a citizen of Georgia age 12 who was admitted to the hospital upon application by his adoptive mother and stepfather pursuant to the challenged statute, Ga. Code § 88-503.1, and also admits that plaintiff J.L. would testify that he is being held against his will.

5.

The allegations of paragraph five (5) of the Complaint are admitted and defendants show by way of further answer that there was not an adversarial proceeding prior to the plaintiff's J.L. admission because he was voluntarily admitted pursuant to [3] the challenged statute, Ga. Code § 88-503.1, and also admits that plaintiff J.L. would testify that he is being held against his will.

6.

Defendants admit that plaintiff J.R. is a citizen of Georgia, age 12, who was committed by the Stephens County Department of Family and Children Services pursuant to Ga. Code § 88-503.1 and defendants further admit that plaintiff J.R. would testify that he is being held against his will.

7.

The allegations of paragraph seven (7) of the Complaint are admitted and defendants show by way of further an-

swer that there was not an adversarial proceeding prior to the plaintiff J. R.'s admission because he was voluntarily admitted pursuant to the request of his adoptive mother and after examination by the admitting physician at Central State Hospital (now Central Georgia Regional Hospital).

8.

The allegations of paragraph eight (8) of the Complaint are admitted.

9.

The allegations of paragraph nine (9) of the Complaint are admitted.

10.

The allegations of paragraph ten (10) of the Complaint are admitted.

11.

The allegations of paragraph eleven (11) of the Complaint are admitted.

[4]

12.

The allegations of paragraph twelve (12) of the Complaint are admitted.

13.

The allegations of paragraph thirteen (13) of the Complaint are admitted.

14.

The allegations of paragraph fourteen (14) of the Complaint are admitted and defendants show by way of further answer that plaintiff was diagnosed by the admitting physician as a hyperkinetic child and that he had unsocialized aggressive reaction of childhood.

15.

Defendants admit that plaintiff J.L. was admitted by adoptive mother and stepfather. Defendants can neither admit nor deny the remaining allegations of paragraph fifteen (15) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

16.

The allegations of paragraph sixteen (16) of the Complaint are denied.

17.

The allegations of paragraph seventeen (17) of the Complaint are admitted except defendants show that administrative procedures were used to determine the appropriateness of hospitalization and plaintiff was voluntarily committed to the hospital and therefore [5] was not the subject of an adversarial proceeding.

18.

Defendants admit that J.L. was confined in Central State Hospital from May 18, 1970 through September 18, 1972 when he was released on furlough and after that furlough he has been continually confined since that day. Defendants can neither admit nor deny the remaining allegations of paragraph eighteen (18) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

19.

The allegations of paragraph nineteen (19) of the Complaint are admitted accept that Defendants show by way of further answer that a relinquishment to Central State Hospital is not a legally binding document.

20.

Defendants deny that J.L. has been inappropriately or unconstitutionally institutionalized. Defendants can neither admit nor deny the remaining allegations of paragraph twenty (20) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

21.

Defendants admit it would be appropriate for plaintiff J.L. to attempt to live in a less drastic environment, in a specialized foster home for example but show by way of further answer that at the present time they know of no specific foster home available for plaintiff J.L. Defendants can neither admit nor deny the remaining allegations of paragraph twenty-one (21) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

22.

The allegations of paragraph twenty-two (22) of the Complaint are denied.

[6] 23.

The allegations of paragraph twenty-three (23) of the Complaint are denied and defendants show by way of further answer that plaintiff J.L. is presently in the least drastic environment which is available for his care and treatment.

24.

Defendants admit that J.L. remained confined at Central State Hospital apparently against his will but they deny the remaining allegations of paragraph twenty-four (24) of the Complaint.

25.

The allegations of paragraph twenty-five (25) of the Complaint are admitted except that defendants would show that plaintiff J.R. was, at the time of his admission, mildly retarded or had a borderline normal level of intelligence.

26.

The allegations of paragraph twenty-six (26) of the Complaint are admitted except that defendants can neither admit nor deny that plaintiff J.R. lost his place in six foster homes to a more favored child for want of information sufficient to form a belief as to the truth or falsity of the allegation.

27.

Defendants admit that plaintiff J.R. would testify that he does not wish to stay at Central Georgia Regional Hospital. Defendants can neither admit nor deny the remaining allegations of paragraph twenty-seven (27) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

28.

The allegations of paragraph twenty-eight (28) of the Complaint are denied.

[7] 29.

The allegations of paragraph twenty-nine (29) of the Complaint are admitted except defendants show that administrative procedures were used to determine the appropriateness of hospitalization and that plaintiff J.R. was voluntarily admitted to the hospital and therefore was not given an adversarial hearing.

30.

Defendants admit that it would be appropriate to try to place J.R. in a specialized foster home and that none has been available since that time but defendants can neither admit nor deny the remaining allegations of paragraph thirty (30) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

31.

The allegations of paragraph thirty-one (31) of the Complaint are admitted.

32.

The allegations of paragraph thirty-two (32) of the Complaint are admitted.

33.

Defendants deny that J.R. has been inappropriately or unconstitutionally institutionalized. Defendants can neither admit nor deny the remaining allegations of paragraph thirty-three (33) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

34.

Defendants can neither admit nor deny the allegations of paragraph thirty-four (34) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

35.

The allegations of paragraph thirty-five (35) of the Complaint are denied.

[8] 36.

The allegations of paragraph thirty-six (36) of the Complaint are denied and defendants show by way of

further answer that plaintiff J.R. has been placed in the least drastic environment available for his care and treatment.

37.

Defendants admit that J.R. remains confined at Central Georgia Regional Hospital and that he would testify that he is confined against his will. Defendants deny the remaining allegations of paragraph thirty-seven (37) of the Complaint.

38.

The allegations of paragraph thirty-eight (38) of the Complaint are admitted.

39.

Defendants admit that pursuant to Ga. Code § 88-503.1(a) a parent or guardian may voluntarily commit a child to a state mental health facility regardless of a child's opposition to admission and that there is no provision in the code for a hearing prior to a voluntary admission to determine the appropriateness or necessities of such action. Defendants deny the remaining allegations of paragraph thirty-nine (39) of the Complaint and show by way of further answer that the admission procedures protect the child's interest and that in this manner the child is able to influence the decision which results in his admission to an institution.

40.

The allegations of paragraph forty (40) of the Complaint are denied.

41.

The allegations of paragraph forty-one (41) of the Complaint are denied.

[8]

42.

The allegations of paragraph forth-two (42) of the Complaint are denied.

[9] 43.

The allegations of paragraph forth-three (43) of the Complaint are denied. Defendants jointly demand a jury trial on all issues of disputed fact with regard to plaintiffs' second claim for relief for ten thousand dollars ($10,000) damages for each of the named plaintiffs.

44.

The allegations of paragraph forty-four (44) of the Complaint are denied.

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ROBERT S. STUBBS, II
Chief Deputy Attorney General

/s/ DON A. LANGHAM
DON A. LANGHAM
Deputy Attorney General

/s/ TIMOTHY J. SWEENEY
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Senior Assistant Attorney General

/s/ DOROTHY Y. KIRKLEY
DOROTHY Y. KIRKLEY
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IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA MACON DIVISION

(Caption omitted in printing)

[1] **AFFIDAVIT OF JANET SCOTT**

I, Janet Scott do hereby swear or affirm the following to be true.

I presently reside at 240 Richards Drive, Milledgeville; my mailing address is P.O. Box 1076, Milledgeville, Georgia.

I have a Masters Degree in Social Work and am presently employed by Central State Hospital, Milledgeville, Georgia, in the position of Social Worker III.

From August 1968 through March 1971 I was the Social Worker in the Children's Building, part of the C & A Unit, of Central State Hospital.

I first came into contact with Joey Lister in March 1970, as an out-patient. It was my understanding that his step-father had contacted Col. Schuyler, who in turn contacted Dr. Portuondo, Unit Director, C & A Unit regarding out-patient services. On March 17, 1970 I had my first meeting with Joey and his parents on out-patient status. I met with Joey and his family approximately once per week, for about two months, while he was on out-patient status. These meetings consisted of individual and parent therapy. I was the primary therapist in this case on out-[2]patient and in-patient status.

Through these meetings I became increasingly aware of the problems that Joey and his parents had. I became

aware that Joey was being held responsible for the verbalized problems within the home but, that these problems seemed primarily to belong to the mother and step-father. It was my opinion that Joey was being scape-goated by his parents for their difficulties. My impression was that Joey was neither psychotic nor hyperkinetic. I concluded that it was not really in Joey's best interest to be hospitalized but, that placement in another home environment might have best met his needs. In a different home environment, one of love and acceptance, I doubt that Joey would have experienced the problems attributed to him, and with which he had to deal.

The circumstances involved in Joey's adoption, at 8 hours old, I believe contributed to the situation that evolved in the eventual hospitalization of him. The adoptive mother and her first husband, Dr. Joe Lister, were invited to dinner at a home of a physician friend, with whom Dr. Lister arranged the adoption of this out-of-wedlock boy without his wife's awareness; the physician friend felt the marriage to be rather shaky and decided that, in order to survive, it needed a child.

The eventual divorce of the Lister's, and the adoptive mother's assuming total responsibility for the care and supervision of Joey, plus the unusual circumstances involved in the initial adoption (for which Mrs. Lister was prepared neither emotionally nor for the necessary items required in the care of an infant) I believe contributed to the basic negative feelings of this mother for this child, and contributed to the rejection of Joey exemplified by his admission to C.S.H. The mother's remarriage also contributed to her need to reject Joey and "start over again"; I did not feel that Mr. Shermer ever really wanted Joey in his new marriage.

From the time of Joey's admission and until I left the C & A Unit, in March 1971, nothing occurred during his course of hospitalization that led me to alter my impression that hospitalization was not in his best interest. During this period of time I felt that an adoptive home, rather than a foster home, would best meet his needs. Some permanency was needed that adoption could provide.

At the time of the decision to admit Joey to the C & A Unit, made by Dr. Portuondo, Unit Director, I was not consulted as to my recommendation regarding his need for hospitalization.

My contact with Jimmy Ramey, prior to my departure from the C & A Unit in March 1971, was quite minimal. I was aware that the reason for his admission, as shared with me, was that Stephens County DF & CS had run out of foster homes and felt they had no other alternative than hospitalization. At this time my reaction was that such a reason for hospitalization was indeed unusual if not inappropriate.

18 Nov. 1975 /s/ JANET SCOTT
Date JANET SCOTT

/s/ CAROLYN R. BLOODWORTH
Notary Public, Baldwin County, Ga.
My Commission Expires: 1-6-78.

(SEAL)

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

REVISED STATEMENT OF FACTS

Plaintiff J.L. was adopted when he was 8 hours old. Following the adoption, the adoptive parents experienced marital difficulties, stress, and eventually, the marriage failed.

In June, 1969, when J.L. was 5 years old, J.L.'s adoptive mother remarried. Family tension continued, J.L. had problems in school [See Exhibit #2-B-1; Summary Progress Note: 6/75], and in March, 1970, J.L.'s adoptive mother and stepfather contacted Central State Hospital regarding out-patient services. After less than 8 weeks of out-patient services which consisted of weekly sessions of both individual therapy for J.L. and parent therapy [See P-1; Affidavit of Janet Scott, Social Worker], J.L. was "voluntarily" admitted by his adoptive mother and stepfather to Central State Hospital on May 18, 1970.

The diagnosis given at the time of admission was "Hyperkinetic reaction of childhood; predisposition: poor home environment." [See Exhibit #1-I]. However, admission notes written by Dr. Zapatera (now Gutierrez) state: "I wonder if he was hyperkinetic . . . he does not look like that now?" [See also Exhibit #1-G-1 and 2].

For J.L., at 6 years of age, the familial situation was unstable; there was a traumatic point and he related to this with a good deal of frustration, irritability, hyperactivity, the school couldn't handle him, the family

[2]

couldn't handle him, and no one wanted him. It is not unusual to see hyperactive [2] reaction in children exposed to a traumatic situation. [See p. 18 of transcript of testimony of Dr. Wayne Hodges].

In November of that year, J.L. was given a form notice of his right to discharge as a voluntary patient. He signed the receipt of that notice when he had just turned 7 years of age. [See Exhibit #3]

J.L. was confined in Central State Hospital from May 18, 1970, through September 18, 1972, when he was released on furlough to his adoptive mother and stepfather. Within 10 days he was returned to the institution by them. It was reported that: "the furlough did not work out because of the stress of the family situation and the inability of the school to effectively discipline J.L.." [See Exhibit #2-B-1; Summary Progress Note: 6/75]. He has been continuously confined in the hospital since that date.

Following the birth of her own child to her second marriage, J.L.'s adoptive mother joined with his adoptive father in April, 1974, in attempting to voluntarily relinquish their parental rights to Central State Hospital. [See Exhibit #4]. J.L. has seen neither his adoptive parents nor his stepfather since that date.

As early as 1973, over two years ago, hospital personnel recommended specialized foster care for J.L. [See p. 7 of transcript of testimony of Dr. Gutierrez]. That recommendation was continually reaffirmed and documented in hospital records: "Continued hospitalization would not provide the emotional climate necessary to meet J.L.'s needs. Recommendation: J.L. be considered for foster home placement with continued out-patient therapy." [See Exhibit #5-A-2; Psychological Evaluation:

[2]

6/75]. "Foster care would be most beneficial . . . he is obviously suffering from some degree of institutionalization and should experience success in a loving, concerned relationship as soon as possible." [See Exhibit #2-B-4 and 5; Summary Progress Note: 6/75].

[3]

Specialized foster care remains the recommendation of the psychologist and psychiatrist on J.L.'s ward at the present time. [See p. 7 of transcript of testimony of Dr. Gutierrez; p. 17 of transcript of testimony of Dr. Hodges].

PLAINTIFF J.R.

In November, 1962, at the age of 3 months, J.R. was declared a deprived child and removed from the home of his natural parents. He has had no contact with his natural parents since that time. Stephens County Department of Family and Children Services was given temporary custody of J.R. at that time, and eventually secured permanent custody "for the purpose of placing said child for adoption." [See Exhibit #8].

J.R.'s life for the next seven years consisted of 2 hospital visits and placement in 5 foster homes. In his first foster home, J.R.'s foster parent was a widow who, in addition to J.R., took care of another infant, and 3 younger children. It was felt that "he suffered a lack of stimulation and attention" in that environment, and was subsequently placed, after hospitalization for medical problems, in two other foster homes. J.R.'s positive adjustment to his fourth foster home was cut short due to the illness of that foster mother and the financial inability of the fourth set of foster parents to care for J.R. J.R.'s fifth foster placement was also successful initially, however, when he started acting out, those foster parents, in

their early 60's, decided they could not handle this seven year-old boy. [See Exhibit #9-A-1 and 2; Summary for Placement Resource].

On May 26, 1970, Dr. John Curtis, Psychiatric consultant at Stephens County Mental Health Clinic where J.R. had been receiving services for approximately one year stated: "I feel it would be of benefit to him . . . to stay in the foster home—for an additional year since he has been in seven different foster homes and this must be very upsetting to him, and if he has to [4] move, it will be even more upsetting." [See Exhibit #9-B-8; Stephens County Mental Health Clinic Records].

Nevertheless, on June 26, 1970, J.R. was "voluntarily" admitted to Central State Hospital by his guardian, Stephens County Department of Family and Children Services.

He was diagnosed as having Borderline Mental Retardation and Unsocialized Agressive Reaction of Childhood. [See Exhibit #7-C; Admission Summary]; however, screening at that time indicated he was not retarded. [See Exhibit #7-I; Interoffice Correspondence]. No answer was given on the Personal History admission form as to what aspect of the patient's behavior made hospitalization necessary [See Exhibit #7-F-3; Personal History]. It was noted that "this boy has been at seven years of age in six different foster homes. We feel that that is a traumatic experience." [See Exhibit #7-H-3; Psychiatric Examination].

The admitting physician concluded that hospitalization was appropriate because J.R. "would benefit from the structured environment and would be enrolled in school activities and would enjoy living and playing with boys of the same age." [See also Exhibit #7-H-3].

[4]

Recommendations for foster home placement were made in early 1973 [See p. 10 of transcript of testimony of Dr. Gutierrez] [See also Exhibit #9-A-2 and 4; Summary for Placement Resource: 6/73]: "Central State Hospital has for some months been requesting long term foster care or (an) adoptive home . . . it is felt that (J.R.) will now only regress if he does not get a suitable home placement as soon as possible . . . (he) has received maximum benefits from Central State's program."

This recommendation was subsequently reaffirmed and documented in the hospital records: "efforts to obtain a foster placement should be primary at this time lest J.R. become a permanently institutionalized child." [See Exhibit #10-A-2; Psychological Evaluation: 8/73]. "Foster care is recommended." [See Exhibit #10-C; Restaffing: 11/74].

[5]

At present, J.R.'s psychologist indicates: that J.R. "is just a mildly retarded individual who needs structure and supervision but could function much better in a setting characterized by . . . a lot less structure . . . continued

hospitalization would be harmful for J.R." [See pp. 12-13 of transcript testimony of Dr. Wayne Hodges].

Respectfully submitted,

/s/ DAVID GOREN

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[1]

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

STIPULATION OF FACTS FOR THREE-JUDGE HEARING

Plaintiffs J.L. and J.R. and the class of children they represent, through their attorneys, and Defendants T.M. (Jim) Parham, W. Douglas Skelton, M.D., and W. T. Smith, M.D., through their attorneys, stipulate to the following facts for the purpose of this civil action:

1.

Plaintiff J. L. was admitted to Central Georgia Regional Hospital (formerly Central State Hospital) on May 18, 1970, upon application by his adoptive mother and stepfather pursuant to Ga. Code § 88-503.1. He was six (6) years old at the date of his admission. See Exhibit #1.

2.

J.L. has normal intelligence and at the time of his admission to the hospital was diagnosed as having hyperkinetic reaction and adjustment reaction to childhood. He had previously received some treatment as an outpatient for approximately two months prior to the date of his admission. The admitting physician determined that hospitalization was appropriate because J.L. could "not function outside the hospital and admission might be helpful." See Exhibit #2.

[2]

3.

J.L. was admitted in accordance with Ga. Code § 88-503.1 and thus prior to his admission, there was no

[2]

formal or informal administrative or judicial hearing statutorily required or held. He was therefore not given notice, counsel, the opportunity to present evidence, to subpoena witnesses and documents, confront and cross examine witnesses, and expert examination and assistance by an expert not employed by the Department of Human Resources and other procedural safeguards associated with an administrative or judicial hearing in order to determine his need for hospitalization.

4.

J.L. was confined in Central Georgia Regional Hospital from May 18, 1970, through September 18, 1972, when he was released on furlough. Within ten (10) days he was returned to the institution by his adoptive mother and stepfather. It was reported that the furlough did not work out because of the stress of the family situation and the inability of the school to effectively discipline J.L. He has been continuously confined in the hospital since that date. See Exhibit #2.

5.

On November 4, 1970, J.L. was given written notice of his right to discharge. That notice informed him that his discharge may be conditioned upon the consent of his parents. He signed his receipt of that notice when he was seven years old. A copy of that notice is attached as Exhibit #3.

6.

In April, 1974, J.L.'s adoptive parents attempted to voluntarily relinquish their parental rights to the hospital. J.L. has not seen his adoptive parents since that date. See Exhibit #4.

[3] 7.

J.L. would testify that he does not wish to be confined in a State Mental Hospital.

8.

The opinion of Central Georgia Regional Hospital personnel with regard to J.L.'s need for hospitalization is found in Exhibits #2 and 5 attached hereto.

9.

On October 31, 1975, the Department of Family and Children Services of Baldwin County petitioned the Juvenile Court of that county for temporary custody of J.L. On that same day, Judge George Jackson granted the Department of Family and Children Services of Baldwin County temporary custody of J.L. See Exhibit #6.

10.

J.L. has not been placed in a specialized foster home. A specialized foster home is defined by the defendants to mean a home in which the foster parents are enabled by training and experience to provide care for children who have been diagnosed as having severe physical, mental or emotional handicaps and who would benefit from the intensive care provided by such foster parents. A one hundred twenty-five ($125.00) dollars a month service fee is paid to each specialized foster home in addition to the per diem rate for each child. There is a limit of two children for each specialized foster home. Medical or psychiatric treatment for children in specialized foster homes is paid for by the state or county in addition to the per diem rate and service fee.

11. [4]

Plaintiff J.R. was committed to Central Georgia Regional Hospital on June 26, 1970 upon application of his Guardian, Stephens County Department of Family and Children Services pursuant to Ga. Code § 88-503.1. He was seven years old at admission. See Exhibit #7.

12.

Upon admission, J.R. was diagnosed by one report as not being mentally retarded and another report as being borderline mentally retarded. He was also diagnosed as having "aggressive reaction of childhood." The admitting physician determined that hospitalization was appropriate because J.R. would "benefit from the structured environment and would be enrolled in school activities and would enjoy living and playing with boys of the same age." See Exhibit #7.

13.

J.R. had been placed in the custody of the Stephens County Department of Family and Children Services after the Juvenile Court of that County declared him to be a deprived child and removed him from the home of his natural parents. J.R. has not had contact with his natural parents since removal from their home. See Exhibit #8.

14.

J.R. has had five foster home placements prior to admission. He received some treatment as an out-patient at the Stephens County Mental Health Clinic from May 22, 1969 until his admission to the hospital. See Exhibit #9.

15.

J.R. was admitted in accordance with Ga. Code § 88-503.1 and thus prior to his admission, there was no

formal or informal administrative or judicial hearing statutorily required [5] or held. He was therefore not given notice, counsel, the opportunity to present evidence, to subpoena witnesses and documents, confront and cross examine witnesses, and expert examination and assistance by an expert not employed by the Department of Human Resources and other procedural safeguards associated with an administrative or judicial hearing in order to determine his need for hospitalization.

16.

J.R. has had no contact outside the hospital for the last five years except for approximately four temporary holiday visits to foster homes.

17.

J.R. is presently hospitalized in Central Georgia Regional Hospital and would testify that he does not wish to remain there. The opinion of Central Georgia Regional Hospital personnel with regard to J.R.'s need for hospitalization is found in Exhibit #10 attached hereto.

18.

J.R. has not been placed in a foster home or an adoptive home.

19.

A portion of the class of children represented by plaintiffs were admitted to regional mental health hospitals in accordance with Ga. Code § 88-503.1, and thus, prior to their admission, there was no formal or informal administrative or judicial hearing statutorily required or held. They were therefore not given notice, counsel, the opportunity to present evidence, to subpoena witnesses and documents, confront and cross examine witnesses, and

expert examination and assistance by an expert not employed by the Department of Human Resources and other procedural safeguards associated with an [6] administrative or judicial hearing in order to determine his need for hospitalization.

20.

Juveniles are confined in state mental health facilities as voluntary patients pursuant to § 88-503.1 who would testify that they are being confined against their will.

21.

The general admission procedures to Central State Hospital for juveniles admitted by their parents or guardian pursuant to Ga. Code § 88-503.1 is as follows:

(a) Parents or guardians bring their child to the admissions unit in the Powell Bldg.

(b) Psychology personnel screen the child for evidence of mental retardation.

(c) If there is evidence of mental retardation, the child is then screened by the mental retardation unit for admission to that unit.

(d) If the child is not mentally retarded, he is then screened by psychiatric unit admitting physician.

(e) If the physician finds the child to be appropriate for admission, the parent or guardian then signs voluntary admission papers and the child is admitted into the facility.

22.

Admission of a child to a private residential psychiatric treatment facility is made upon application of a parent and upon the determination of the admitting physician that the child is suitable for residential treatment and not

following a formal or informal judicial or administrative hearing.

[7]

23.

There is no state-wide statute, regulation or policy establishing the frequency of periodic reviews for children committed to state mental hospitals pursuant to Ga. Code § 88-503.1. The superintendent determines policies regarding periodic review of cases by staff personnel within each regional mental health hospital.

24.

There is no judge, hearing officer or evaluator not employed by the Department of Human Resources who conducts periodic reviews in any state mental health facility with respect to juveniles admitted in accordance with Ga. Code § 88-503.1.

25.

The numbered exhibits referred to above and attached hereto are incorporated herein by this reference and made a part of this stipulation.

Agreed and stipulated to this _____ day of November, 1975.

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Senior Assistant Attorney General

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Assistant Attorney General

Attorneys for Defendants

EXHIBIT # 1

A. Inter-Office Correspondence from J. T. Harris

B. Admission Summary

C. Application for Voluntary Admission

D. Notice to Voluntary Patient

E. Representation Form

F. Personal History and Treatment

G. Admission Note

H. Admission Record

I. Diagnosis

MILLEDGEVILLE STATE HOSPITAL

Georgia Department of Public Health

INTER-OFFICE CORRESPONDENCE

TO: ALL ADMISSION EMPLOYEES DATE 5-15-70

FROM: J. T. Harris

SUBJECT: Joey Lister

Joey Lister is to be admitted to this hospital on May 18, 1970 from Baldwin County. He is to be sent directly to the Children's Unit 1 South.

JTH:ldl

Exhibit #1-A

ADMISSION SUMMARY

Name of Hospital: CENTRAL STATE HOSPITAL

(Name) (Last)	(First)	(Middle)	(Maiden)	Patient Number
LISTER,	Joey	Mack		172,897

Date of Admission	Type Admission	Type Commitment	Unit/Ward	Modality
5-18-70	First	Vol-Voluntary	08-Children's Unit 1S	In-Patient

Address (Street No. and Name)	(City)	(County) (State and Zip Code)	How long at Present Address	Telephone
Premier Mobile Park	Milledgeville	Baldwin Co., Ga.	Unk	452-30

Race and Sex	Age	Birth Date	Birthplace (City, County, State)	U. S. Citiz
White Male	6	10-1-196[illegible]	Tift Co., Ga.	Yes

Nearest Relative (Name)	Relationship	Address	Telephone
Carrie R. Sherner	Mother	Premier Mobile Park, Milledgeville	452-3

Person Having Legal Custody or Guardianship	Address	Telephone No.	Child Live
NA			

Person To Notify in Emergency	Relationship	Address (Home and Work)	Telephone
Dr. and Mrs. Wilbur Baugh	None	Gordon Rd., Milledgeville, Ga.	452-2

Patients Representatives (Name)	(Street No. and Name)	(City, State and Zip Code)
1st Carrie R. Sherner	Premier Mobile Park	Milledgeville, Ga.
2nd Kenneth Lee Sherner	Premier Mobile Park	Milledgeville, Ga.

Marital Status	Number of Children	Education (No. of Years)	Employed or Retired	How Long Employed	Patient's Occupation	Spouse's Oc
Single	NA	First Grade	NA	NA	NA	NA

Name and Address of Employer (Patient)	Name and Address of Employer (Spouse)
NA	NA

Last Day Patient Worked	Patient	Annual Income Family	Social Security Number	Receives S.S. Benefits	Health Ins. Number
NA	none	$9,000	None	No	NA

Veteran	Ser. or Serial Number	Receives Military Benefits (including VA)	Receives Welfare Benefits	Receives Child Benefits
No	NA	No	No	No

Hospital Insurance	Policy No.	Group No.	Insurance Company (Name and Address)
Yes			Prudential Ins. Co.

Religious Preference	Name and Address of Church
Baptist	Unk

Father's Name	Birthplace	Living	Age	S. S. Number	Veteran	Religious Preference
Joe Lister	Unk	Yes				

Mother's Name	Birthplace	Living	Age	S. S. Number	Veteran	Religious Preference
Carrie R. Sherner	Tift Co.	Yes				

Family Physician (Name and Address)
Dr. James Baugh, Milledgeville, Ga.

Related Treatment (Name and Address) — IP — OP — Dates Received: From — To

None

Referral Source (Name and Address)
Dr. James Baugh, Milledgeville, Ga.

Admitting Clerk: JEB — Time Adm: 2:00

Admitting Diagnosis (Mental and Physical):
Emotionally disturbed.

Final Diagnosis:
Hyperkinetic Reaction of Childhood. #308.0

No. Days	Movement		
	Date	Unit	Mode
3 days			
2 days	9-4-72	Ch 1S	Discharged

Type Separation: Discharged — Disposition: Parents
Condition: Improved — Progress: Fair
Cause of Death: — Autopsy:

Date Discharged: 9-4-72 — Physician's Signature: [illegible]

SBH 1760 (Revised 9-70)

Exhibit #1-B

GEORGIA DEPARTMENT OF PUBLIC HEALTH
APPLICATION FOR VOLUNTARY ADMISSION TO
Central State HOSPITAL

(By Authority of Section 88-503.1, Georgia Health Code, Ga. Laws, 1968, pp. 5050-5051)

I, JOEY MACK LISTER (Type or Print Full Name) Age 6

residing at PREMIER MOBILE HOME PARK-EATONTON ROAD (Street Address)

MILLEDGEVILLE (City) GEORGIA (State)

BALDWIN (County) request admission to CENTRAL STATE Hospital on a voluntary basis and

hereby agree to abide by the rules of the Hospital (see back of page) and to leave the Hospital willingly when informed by the medical staff that I no longer need to stay.

Joey Lister
by K.L. Sherner
Signature

Witness J.B. Baugh
Title Clerk IV
Address CSH

NOTE: Parent or guardian must sign below if applicant is under 18 years of age, or under 14 years of age if admission to an Evaluating Facility is desired, or by Guardian if applicant has been adjudged legally incompetent.
As parent or guardian of the above named individual I agree to all of the provisions of this application.

Carrie R. Sherner
Signature of Parent/Guardian
MAY 18, 1970
Date

Witness Josephine Boyd
Title Notary Public
Address 132 Simmons Road, Milledgeville, Ga.

☐ Family History record included ☐ To Follow by Mail

EXHIBIT 1-C

SBH 1969 [Section 88-503.1] Georgia Department of Public Health

NOTICE TO VOLUNTARY PATIENT OF RIGHTS TO DISCHARGE

(By Authority of Section 88-503.4, Georgia Health Code, Ga. Laws 1969, pp. 505-545)

To: (Voluntary Patient) Joey Mack Lister

Hospital Central State

Date 5-18-70

Please be advised that you, your legal guardian, parent, spouse, attorney, or adult next-of kin may request your discharge in writing at any time after five days following your admission to this hospital, excluding Saturdays, Sundays, and legal holidays, subject to the following provisions:

1) If you have been admitted on your own application and a request for your discharge is made by a person other than yourself, your discharge may be conditioned upon your agreement thereto.

2) If you have been admitted prior to your 18th birthday on the application of your parent or guardian, your discharge prior to becoming 18 years of age may be conditioned upon the consent thereto of such parent or guardian.

3) If you have been admitted as an adjudged incompetent on the application of your guardian, your discharge prior to a legal restoration of competency may be conditioned upon the consent thereto of your guardian.*

Within 5 days, excluding Saturdays, Sundays, and legal hospital, after receipt of your written request for discharge by the Superintendent, you will be discharged, unless your attending physician finds that your discharge would be unsafe for you or others, in which case proceedings for your involuntary hospitalization will be initiated within the 5-day period as provided for by law.

Notwithstanding the above, you may also be discharged if, in the judgment of your attending physician or the Superintendent, such discharge would contribute to the most effective use of this hospital in the care and treatment of mentally ill persons, or if in their judgment, you no longer require hospital care.

James B Cleary Superintendent

I hereby acknowledge receipt of this notice.

Date 5-18-70

x Joey Mack Lister Patient
by K L Skinner

cc First Representative
Second Representative
Clinical Record (receipted copy)

EXHIBIT #1-D-1

MH 1011 (Section 88-503.4) Georgia Department of Public Health

_____ Hospital

RULES AND REGULATIONS FOR VOLUNTARY ADMISSION TO _____ HOSPITAL

1. For voluntary admission, arrangements must be made with the Superintendent or his representative in advance of coming to the Hospital for confirmation of availability of beds. This may be done by telephone or in writing.

2. When admitted on a voluntary basis, a patient agrees to submit to all of the rules and regulations of the Hospital.

3. For a voluntary admission, a patient must have sufficient mental clarity to be responsible for and willingly sign the Application for Voluntary Admission.

4. For a voluntary admission, a patient must recognize the nature of his condition and the purpose for which he is admitted.

5. A patient will not be accepted on a voluntary basis when criminal charges or indictment are pending against said patient.

6. When admitted on a voluntary basis, a patient agrees for the doctors at the Hospital to administer any type of standard treatment deemed advisable.

7. A voluntary patient may request a discharge from the Hospital by addressing the Superintendent in writing in accordance with Section 88-503.3, Georgia Health Code, Ga. Laws, 1969, pp. 505-545.

NOTE: Any item in question which is not covered in the above rules and regulations may be directed to the Division of Mental Health, Georgia Department of Public Health, the hospital, your local health department or your local physician.

EXHIBIT #1-D-2

5-18-70
(DATE)

Joey Mack Lister
NAME

172,897
HOSPITAL NUMBER

Children's Unit I-S
WARD

1st REPRESENTATIVE: Carrie B. Shermer (Mother) 452 3053
NAME

Premier Mobile Park
STREET ADDRESS

Milledgeville Ga
CITY STATE

31061
ZIP CODE

2nd REPRESENTATIVE: Kenneth Lee Shermer (Step father) 452 5:8
NAME

Premier Mobile Park
STREET ADDRESS

Milledgeville Ga.
CITY STATE

31061
ZIP CODE

1. Patient's Legal Guardian
2. Spouse
3. An Adult Child
4. Parent
5. Attorney
6. Adult Next-of-kin
7. Adult Friend

EXHIBIT #1-E

PERSONAL HISTORY AND TREATMENT PERMIT
CENTRAL STATE HOSPITAL
MILLEDGEVILLE, GEORGIA

Please Answer All Questions

Patient's Name: Mr. Miss Mrs. LISTER (Last) JOEY (First) MACK (Middle and Maiden)

Hospital Case No. _____ (Supplied by hospital after admission) Date of Admission 5-18-70 County: BALDWIN

Age: 6 YEARS Race: CAUC. Date of Birth: OCTOBER 1, 1963 Social Security No. NONE

Place of Birth: TIFT COUNTY-GEORGIA How long a resident of Georgia LIFE

Legally (court appointed) Guardian: CARRIE RUTLAND SHERMER - EATONTON ROAD-MILLEDGEVILLE, GA.
Name Address

Guardian of: Person _____ Property _____ Both X

Address of pt. prior to admission: PREMIER MOBILE PARK (Street) MILLEDGEVILLE (City) 31061 (Zip Code)

Give Name and Relationship of Other Adults in Household.
KENNETH LEE SHERMER (Name) STEP-FATHER (Relationship)

Are there any drugs to which patient is allergic? (Name them) NONE KNOWN

If patient is presently taking any types of medication, please list: RITALIN

Patient is: Single [X] Married [ ] Widowed [ ] Divorced [ ] Separated [ ] How long _____

If the patient has been married before, give the following information for each marriage:

Spouse's Name	Address	Year married	Year separated or divorced	Reason

If the patient has children, give the indicated information for each:

Name	Address

With whom will patient live when he leaves hospital? MOTHER AND STEP-FATHER
PREMIER MOBILE HOME PARK-EATONTON ROAD, MILLEDGEVILLE, GA.
Name and address

What is the patient's principal occupation? N/A

Did the patient work regularly in the last year? _____ Average Monthly Income _____

EXHIBIT #1-F-.

ther persons or the patient himself, are working and have contributed to the patient's support, give following information:

KENNETH LEE SHERMER	STEP-FATHER	ANNOUNCER(RADIO)	370.00
CARRIE R. SHERMER	MOTHER	COUNTY HOSPITAL	360.00
e	Relationship	Principal Occupation	Avg. Monthly Income

as the patient receive income from any of these sources: (Underline)

ocial Security, Welfare, Veterans' Administration, Railroad Retirement? Amount NONE

If patient is 65 years of age or older, is he/she signed up for Medicare? _____

Part A (Hospital) _____ Part B (Medical) _____

Hospital Insurance Co. (Medicare) _____

If any person close to the patient receives income from these sources and shares this income with the patient, indicate following:

Name	Relationship	Source	Amount

Give highest school grade completed or degree received: NONE

Give the following information on school attendance as indicated:

Age Entered 1ST Was Attendance Regular? YES Grades Good or Bad? POOR TO FAIR

Grades Repeated? NONE Age Left School? 6 Reason? UNCONTROLABLE

If the patient served in the Armed Services, give the following information:

Service	Year entered	Year left	Type Discharge	Service No.	Service Occupation	Claim No.

Is the patient active in church? _____ Denomination? BAPTIST

If the patient was ever arrested, give the indicated information:

Date	Place	Reason	Disposition

Give the following information regarding the patient's parents:

K.L. SHERMER	27	RADIO ANNOUNCER	HIGH SCHOOL
Father (STEP FATHER)	Age	Occupation	Education
CARRIE R. SHERMER	32	X-RAY TECHNICIAN	HIGH SCHOOL, COLLEGE&X-R
Mother	Age	Occupation	Education
JOE M. LISTER	35	DENTIST	UNKNOWN
Step-Parent	Age	Occupation	Education

If parent(s) is deceased, give the age at death and cause: _____

If the patient's parents ever obtained a divorce, give age of patient at the time 3 YEARS

Give the following information regarding siblings, (includes those who may have died or who may be half-siblings):

Name	Age	Address	Occupation (if deceased, give cause)

EXHIBIT #1-F-2

patient has been mentally ill before give the following information:

...ox. Dates of Illness	Physician or Hospital where treated & address

as the patient ever used alcohol excessively? _____ Drugs? _____

If any relative of the patient has been mentally ill, addicted to alcohol or drugs or been in a mental hospital, give the following information:

NONE

Name	Relationship	Nature of Illness	Hospital, if hospitalized

Briefly, what about the patient's behavior makes you feel he needs hospitalization? EXTREMELY AGGRESSIVE, HAS NO REGARD FOR AUTHORITY.

Did this behavior appear suddenly or gradually? PRESENT FROM EARLY AGE

Check any of the following which describes the patient's behavior. Felt someone or something had special control over him, ___ Had fears of being harmed, _____ Heard imaginary voices; _____ Smelled peculiar odors, _____ Saw imaginary persons or things, _____ Thought they were someone else, _____ Experienced loss of memory; _____ Seemed to lose interest in people and things: X Neglected appearance; _____ Spoke angrily to others, X Was physically violent to self or others, X Depressed, X

If the patient has been suicidal, homocidal, violent, or destructive, describe _____

Describe any serious illnesses, injuries or operations as indicated:

Illness, injury or operation	Date	Physician or Hospital where treated and address

If any close relative of the patient or the patient himself has had any of the following illnesses, give the information requested below: Heart Disease, Asthma, Ulcers, Diabetes, Tuberculosis, Epilepsy or Fits, Syphilis, Cancer, Huntington's Chorea, Wilson's Disease, Pick's Disease:

Name	Relationship	Describe Illness

Has the patient ever had convulsions, fits, blackouts, or epilepsy? _____

Were these light or severe? _____ How often did they occur? _____

Name, Address & Relationship of Informant: _____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY DR. AND MRS. WILBUR BAUGH
Name

GORDON ROAD-MILLEDGEVILLE	31061	452-2453
Address	Zip Code	Telephone No.

EXHIBIT #1-F-3

AUTHORIZATION AND TREATMENT PERMIT

Date 5-18-70

I, the nearest relative or guardian, hereby authorize the Superintendent or any Central State Hospital staff member whom he might designate to:

1. Employ any recognized psychiatric treatment, including electro-convulsive therapy, and to perform any and all operations, procedures or treatment that may be necessary or advisable for the benefit and improvement of the patient.
2. Release to other hospitals, physicians, social agencies or other professionally qualified agencies or persons any information which they may desire that is recorded in the medical and psychiatric record of the patient when such would contribute to the treatment of the patient.
3. Arrange for public transportation home for the patient in the event that no responsible relative can come for him when he is ready for release from the hospital.
4. Permit patient to wear and use such personal items as: clothing, jewelry, false teeth, spectacles and I, the nearest relative or guardian, agree to assume full responsibility for the loss and destruction of such articles.

Joey Lister by
Signature of Patient
K. L. Themer

Carrie L. Themer
Signature of Nearest relative or guardian

[illegible]
Witness

CSH-645 Dec 1968

EXHIBIT #1-F-4

CENTRAL STATE HOSPITAL

ADMISSION NOTE

PRESENTING PROBLEM:

This about 6½ y.o. w/male was brought to the Cty by his stepfather, he gave extreme aggressiveness and no regard for authority as reasons for bringing him to the Hospital, this behavior has been growing worse lately. he has been violent and at times he has looked depressed.

IMPRESSION: The boy is attractive and cooperative, asked for his father but came to my office and sat down. he answered some questions about who was he living c̄ and he had no brothers, but later on he started saying "I don't know." I noticed he was in the verge of tears, working

REMARKS: his hands and making circles on the floor c̄ his feet. Asked for a toy, gave a puzzle he could do it in minutes. Final I took him to the dayroom where he was introduced to the other boys.

The boy has been on Ritalin I wonder if he was hyper

ADMISSION DATE: 5/18/70	ADMISSION TYPE: 54
SIGNATURE: [illegible]	DATE: 5/18/70
DATE OF BIRTH:	MARITAL STATUS:

LISTER, JOEY MACK
177 54 10-1-1963
5-18-70 [illegible]
[illegible] BLDG 1 SOUTH

CSH-414 ADMISSION NOTES

EXHIBIT #1-G-1

BEST COPY AVAILABLE

[illegible] looks sad. The short time I stay [illegible] would not let me know if he is really depressed. [illegible] is necessary for [illegible]. Imp Adj react of childhood.

[illegible signature]

2/18/70

EXHIBIT #1-G-2

ADMISSION RECORD

DATE 5-18-70

DESCRIPTION: AGE 6 HEIGHT 47¾ in. WEIGHT 53 lbs. TEMP 98.6 PULSE 88 B/P 84/50 RESP 22

ATTITUDE TOWARD ADMISSION: FEAR ___; WILLING ✓; COMBATIVE ___; WITHOUT UNDERSTANDING OF WHAT IS HAPPENING ___;

PHYSICAL: AMBULATORY ✓; WHEEL CHAIR ___; STRETCHER ___; CRUTCHES ___;
GAIT: STAGGERING ___; ODOR OF ALCOHOL ___; ODOR OF PARALDEHYDE ___; BLIND ___;
PUPILS UNUSUALLY ENLARGED ___; OR UNUSUALLY SMALL ___; COLOR OF EYES ___;

CLOTHING: WELL ARRANGED ✓; DISARRANGED ___; CLEAN ✓; SOILED ___;

SKIN: UNUSUALLY PALE ___; FLUSHED ___; UNUSUALLY MOIST ___; UNUSUALLY DRY ___;
CLEAN ✓; SOILED ___; WAS PATIENT GIVEN A BATH? ✓; TYPE Shower SCARS None (Chart);
SCRATCHES ___; BRUISES ___ (Chart); SCABES ___; PEDICULI PUBIS ___; CUTS ___;
BURNS ___; ERUPTIONS ___; DECUBITUS ___;

HAIR: WELL-GROOMED ✓; DISARRANGED ___; MATTED ___; COLOR OF HAIR Blonde CLEAN Yes;
SOILED ___; EVIDENCE OF PEDICULI ___; HEAD TREATED FOR PEDICULI ___;

ORIENTATION: CAN GIVE NAME Yes; KNOWS WHERE HE IS Yes; KNOWS APPROX. DATE No;

PERSONAL POSSESSIONS: JEWELRY ___; MONEY ___; VALUABLE PAPERS ___; DESCRIBE THESE THREE ITEMS ON BACK OF SHEET: GLASSES ___; TYPE ___; DENTURES ___;
FULL OR PARTIAL ___; BRIDGE ___; DOES PATIENT HAVE PERMISSION TO USE PERSONAL BELONGINGS Yes

MENTAL STATE: DOES NOT ANSWER QUESTIONS ___; DOES NOT SEEM TO UNDERSTAND QUESTIONS ___;
TALKS VERY LITTLE ___; OVERTALKATIVE ___; IS TALK MEANINGFUL Yes;

EMOTIONS: UNWARRANTED FEAR ___; EXPRESSIONS OF HATE ___; TOWARD WHOM ___; IDEAS OF PERSECUTION ___; BY WHOM ___.

IDEAS: STRANGE EXPRESSED THOUGHTS (explain) ___

COMPLAINTS: (any expressions of physical or mental nature) ___

SPECIMEN COLLECTED: URINE Yes; FECES Yes;

LUGGAGE: 1 Ivory C. Suitcase
(Add any pertinent information on back of sheet.)

TRANSFERRED: ___

PATIENT RECEIVED BY: Wilma Anderson
SIGNATURE

CHECKED BY: Wilma Anderson
Irma B. Cummings
SIGNATURE

LISTER, JOEY MACK
172,897 WM 54 10-1-1963
5-18-70 005

CHILDREN'S BLDG 1 SOUTH

SIGNATURE: ___ DATE: ___

CSH-82 ADMISSION RECORD

EXHIBIT #1-H

CENTRAL STATE HOSPITAL

DIAGNOSIS

THIS PATIENT WAS PRESENTED TO THE WARD STAFF AND WAS GIVEN A DIAGNOSIS OF:

DIAGNOSIS: Hyperkinetic Reaction of Childhood, # 308.0

PREDISPOSITION: Poor home environment

STRESS: Unknown

IMPAIRMENT: Moderate

PROGNOSIS: Fair to guarded

TREATMENT: Hospitalization, Chemotherapy, Milieu Therapy, Special School, and Individual Psychotherapy

TYPE OF ADMISSION
VOLUNTARY -- 54

SIGNATURE
213 DATE 6-30-70

CSH-612 DIVISION

LISTER, JOEY JACK
172,897 M 54 [illegible]
5-18-70 005

CHILDREN'S BLDG. 1 [illegible]

EXHIBIT #1-I

EXHIBIT #2

A. Admission Summary

B. Summary Progress Note - 6/75

C. Final Summary

EXHIBIT #2-A

Admission Summary

ADMISSION SUMMARY

CENTRAL STATE HOSPITAL: 300-171-897

[illegible] JOEY MACK 254-96-0560

9-18-72 (Rec.) First (17) Children's Unit (1) S. In-Patient:

Address	City, County, State		
Prestic Mobile Park	Milledgeville	Baldwin Georgia	unk. 452-308

Race and Sex	Age	Birth Date	Birthplace	
White Male	6	10-1-[illegible]	Tift County, Georgia:	Yes:

Nearest Relative (Name)	Relationship	Address	Telephone
Carrie R. Shermer	Mother:	~~Premier Mobile Park~~, Milledgeville	452-308

Person Having Legal Custody or Guardianship: N/A

Person To Notify in Emergency	Relationship	Address (Home and Work)	Telephone
Mr. & Mrs. Milbur Baugh	None:	Gordon Rd., Milledgeville, Georgia	452-345

Patient's Representatives (Name):
1st Carrie R. Shermer — ~~Premier Mobile Park~~ — Milledgeville, Ga.
2nd Kenneth Lee Shermer — ~~Premier Mobile Park~~ — Milledgeville, Ga.

Marital Status	Number of Children	Education (No. of Years)	Employed or Retired	How long employed	Patient's Occupation	
Single:	N/A	First Grade	N/A	N/A	N/A	N/A

Name and Address of Employer (Patient):
Name and Address of Employer (Spouse):

Last Day Patient Worked	Annual Income Patient	Family	Receives Social Security Benefit	Health Insurance Number
N/A		$2,300	None:	

Veteran	C or Serial Number	Receives Military Benefits (Including VA)	Receives Welfare Benefits	Receives Child Benefits
No:				

Hospital Insurance	Policy No.	Group No.	Insurance Company (Name and Address)
Yes:			Prudential Insurance Company:

Religious Preference	Name and Address of Church
Baptist:	Unknown:

Father's Name	Birthplace	Living	Age	S.S. Number	Veteran	Religious Preference
Joe Lister	unknown:	yes:				

Mother's Name	Birthplace	Living	Age	S.S. Number	Veteran	Religious Preference
[illegible]	Tift Co.	Yes:				

[illegible] Milledgeville, Georgia [illegible]

Referral Source (Name and Address): K.T. Shermer, Box (502), Milledgeville, (Step-Father) — JMC — 8:50

Admitting Diagnosis (Mental and Physical):

EMOTIONALLY DISTURBED:

Final Diagnosis:

HYPERKINETIC REACTION OF CHILDHOOD: 308.00

Disposition

EXHIBIT #2-A-1

EXHIBIT #2-B

Summary Progress Note - 6/75

SUMMARY PROGRESS NOTE June 1975

RE: Joey Mack Lister
CAS. NO.: 172,897
Children's Building
Admission from Baldwin County, 9-12-72
Birthdate: 10-1-63

Custody pending to in July, 1975
Mrs. Ann Etheridge
Baldwin County DFCS
Milledgeville, Georgia

Joey was readmitted to this facility September 18, 1975, after a two week furlough. He had been here for two years being admitted for the first time May 18, 1970, and was placed on furlough September 8, 1972. He was to live at home but attend the School of Special Education here. This arrangement did not work out due to the stress of the family situation and the inability of the school to effectively discipline Joey. Before his furlough if he became disruptive in school, he could be returned to the ward. As an out patient, this could not be done. At that point he could not have functioned in a public school.

He was adopted son of Mrs. Carole Lister [illegible] 8 hours old.

Following the adoption the Lister marriage failed. There were some stormy, unhappy times for the whole family. Mrs. Lister was granted custody of Joey and there was never a meaningful relationship established with the father before or after the divorce.

Mrs. Lister married Mr. Ken Shermer in June, 1969, and she states he helped Joey for a while. When Joey entered Northside school [illegible] classroom behavior was disruptive [illegible]

in March, 1970.

Mr. . Shermer states as a baby he was hyperactive and destructive, getting worse as he got older ... could get into more things. He was unable to finish anything or sit still and watch T.V. The reasons for Joey's admission were hyperactivity, uncontrollable, disruptive behavior and unable to adjust to school. He was also destructive.

Shortly after admission, the family tried to cooperate with family therapy. Mr. Shermer even though apparently movitated at first became discouraged with Joey's cyclic behavior and no consistent improvement. Mrs. Shermer was threatened by the process of really changing the situation. She felt a lot of guilt about Joey's condition.

She really cared for Joey and it was a painful, traumatic decision to give him up. It is to her credit that she dealt with the feelings of helplessness and hopelessness Joey created for her in the hope he could be put in a successful foster home. Her own marriage was threatened by Joey's disruptive behavior in the home and this was the only [illegible] ... natural child's welfare. Both she and Dr. Lister relinquished

[illegible]

Since Joey's 5 years here he has improved some only to revert to his usual disruptive, demanding behavior. He has been tried on Ritalin, Amphetamine Sulfate 5 mg., and various tranquilizers with no consistent improvement. At present he is on Navane 5 mg. bid p.o. He is an insecure child who feels he must have your attention by his endless request. The older he gets and the more hopeless he feels, he has begun to be physically [illegible] both to the staff and to the other children.

[illegible] in allergic [illegible]

[illegible] symptoms. Restriction from milk has helped some. He has had frequent treatment with [illegible] for his allergies. He is also prone to skin lesions, minor areas becoming infected and dry skin. When he is under stress his allergies and skin problem is more evident. He was seen in Hemotology Clinic from June, 1973, to January, 1974, for generalized ecchymasis and petechrael rash on his body. It was felt this could have been drug induced from Keflex, an antibotic that he had to take for an infected sutured arm. He does bruise very easily, from the slightest trauma he will turn bluish green. The hematology work up showed Idiopothic Thrombocytopenic Micraytic, Mildly hypochronic anemia. From time to time Joey has to receive a course of treatment with feasal due to a low grade anemia. He was treated successfully with Prednisolone and dismissed from hematology clinic January 30, 1975. Chest x-rays and EEG's have been within normal limits. The examination of his eyes and hearing [illegible] also [illegible]

Joey has adjusted fairly well to the fact he [illegible] to go in foster [illegible] rather [illegible]

place to go. He has been on a few visits. While these visits reve[illegible] no major problems, none of the homes have invited him back. A continuing home for visitor foster care would be the most therapeutic thing that could happen for Joey.

His ward behavior still swings from a nice well behaved child to one who is demanding and nothing could satisfy. He has a low frustration tolerance, [illegible] both the children and staff when thwarted. He [illegible] therapy with the therapist [illegible] ... [illegible] more appropriate behavior. He relates [illegible]

EXHIBIT #2-B-4

Bolduc County DFCS will have a hearing regarding [illegible] in July. Hopefully they will be able to provide resources [illegible] for foster care, which as stated earlier would be the most beneficial step in Joey's interest.

He is going to the Learning Center 1/2 day, four days a week and doing well. His school problems are more behavioral than academic.

Joey would need a specialized foster home or certainly parents who could ride out the storm while he is adjusting. Since he finds it hard to believe he won't be rejected, a warm, supported, truly involved couple will be a neccessity.

Joey has run away on several occassions recently. He states he is so unhappy and would rather be ary place than here. This running away behavior started after the complete deterioration of the homo and I feel this is a bid for attention to his unhappy circumstances.

Even though Joey has functioned under a behavior modification system [illegible] years, [illegible] doesn't fully understand and accept the consequences of his [illegible] Counter, [illegible] it's because he is [illegible]. He blames others often for the difficulty he has and quite often he is in trobble more often than the other children on the ward.

Joey received an IQ of 90 on Form L-M of the Stanford-Binet on 5-25-70 and a score of 88 on the same test April 19, 1972. His achievement scores showed him to be functioning about two years behind his chronological grade level but he has shown improvement since admission. He appears to [illegible] punitive child. He is unable [illegible] natural [illegible] foster parents without a lot of [illegible] [illegible] actually suffering from some degree of insta[illegible]

and she can experience success in a loving concerned relationship as soon as possible.

Joey is an attractive child who, once reassured of your interest, can be a nice child to be around.

Bettie Joyce Harris R.N.
Bettie Joyce Harris, R.N.
Team Leader, 1 South

Odilia Gutierrez
Odilia Z. Gutierrez, M.D.
Director, C & A Unit

EXHIBIT #2-B-5

EXHIBIT #2-C

Final Summary

CENTRAL STATE HOSPITAL

FINAL SUMMARY

ADMISSION DATE: 5-15-70 DATE OF RELEASE: 9-8-72

DIAGNOSIS AND CODE NO: Hyperkinetic reaction of childhood. #308.0

SUMMARY OF TREATMENT: Individual psychotherapy, chemotherapy, recreational, and music therapy. Laboratory tests and chest x-rays reported normal. Patient has had lymphadenities due to small infections of the skin and also urticaria received adequate treatment at Outpatient Clinic. EEG normal.

HOSPITAL COURSE: Patient was admitted because of his disruptive behavior at home and at school too, short attention span and hyperactivity; he was on Ritalin. Patient did not show improvement during the first months in the building but later on he was more quiet and less restless and started going home in a "behavior modification" basis. It worked fairly well for a few weeks. Later on the policy was discontinued and Joey was going home, sometimes he would stay and sometimes they would bring him back before he was supposed to. During all this time, family therapy has been performed and finally

RECOMMENDATION OR DISPOSITION: Keep Joey in special education, get in touch with therapist for help and guidance.

DICTATED BY: Odilia Zapatero, M.D. 101

TYPE OF ADMISSION: Voluntary

9-12-72

FINAL SUMMARY

LISNER, JOEY [illegible]
8xx - 172,897 [illegible] 10-1-63
5-15-70 [illegible]

EXHIBIT #2-C-1

EXHIBIT # 3

Notice to Voluntary Patient of Rights to Discharge

CENTRAL STATE HOSPITAL

NOTICE TO VOLUNTARY PATIENT OF RIGHTS TO DISCHARGE

(By authority of Section 88-503.4, Georgia Health Code, Ga. Laws 1969, pp. 505-45)

TO (Voluntary Patient) Date November 4, 1970

Joey Mack Lister

CSH # 172,897

Please be advised that you, your legal guardian, parent, spouse, attorney or adult next-of-kin may request your discharge in writing at any time after five (5) days following your admission to this Hospital, excluding Saturdays, Sundays, and legal holidays, subject to the following provisions:

1. If you have been admitted on your own application and a request is made by a person other than yourself, your discharge may be conditioned upon your agreement thereto.

2. If you have been admitted prior to your 18th birthday on the application of your parent(s) or guardian, your discharge prior to becoming 18 years of age may be conditioned upon the consent thereto of such parent(s) or guardian.

3. If you have been admitted as an adjudged incompetent on the application of your guardian, your discharge prior to a legal restoration of competency may be conditioned upon the consent of your guardian.

Within five (5) days, excluding Saturdays, Sundays, and legal holidays, after receipt of your written request for discharge by the Superintendent, you will be discharged, unless your attending physician finds that your discharge would be unsafe for you or others, in which case proceedings for your involuntary hospitalization will be initiated within the five-day period as provided for by law.

Notwithstanding the above, you may also be discharged if, in the judgement of your attending physician or the Superintendent

(Superintendent)

I hereby acknowledge receipt of this notice.

Date _____

Joey Mack Lister

(Patient)

EXHIBIT #3

EXHIBIT #4

Relinquishment of Parental Rights

STATE OF GEORGIA

COUNTY OF BALDWIN

RELINQUISHMENT OF PARENTAL RIGHTS

WE the undersigned, CAROLE REBECCA RUTLAND LISTER SHEETER and JOE M. LISTER, both of Baldwin County, Georgia, do hereby freely and voluntarily consent to the placement of our adopted son, to-wit, JOEY LISTER, by and through the CENTRAL STATE HOSPITAL, a state mental institution located in said Baldwin County, Georgia; and.

WE hereby surrender all of our joint and individual parental rights, including the right to his custody and control, and any and all other rights we have or may have, either jointly or individually, under the laws of the State of Georgia, in said child, unto said Central State Hospital and the placement agency or persons thereby designated by said state mental institution.

WE expressly waive any and all other and further notice of placement, if any, of said child, service of notice of placement, including any conferences, meetings, or hearings on said matter and the time and place thereof are also hereby waived.

WE fully understand that we are unequivocably relinquishing any and all of our parental rights for the expressed purposes hereinbefore stated. This document is freely and voluntarily executed by each of us and we fully understand its purport.

This the 25th day of April, 1974.

Carrie Rebecca Pittard Lister, Adm.
CARRIE REBECCA PITTARD LISTER, DECEASED

Signed and sealed

in the presence of:

Brenda W. Snow

Notary Public, Baldwin County, Georgia

This the 7th day of April, 1974.

Joe M. Lister
JOE M. LISTER

Signed and sealed

in the presence of:

Mary R. McClain

My Commission expires 3/3/78
Notary Public, Baldwin County, Georgia

This is to certify that this is a true
and correct copy of the original document.

Mary R. McClain N.P.
Baldwin County, Ga.
Commission expires 3/3/78

EXHIBIT 44-2

GILMORE, WADDELL
& PHILLIPS
ATTORNEYS AT LAW
225 SOUTH WILKINSON STREET
MILLEDGEVILLE, GEORGIA 31061

EXHIBIT #5

A Psychological Evaluation

PSYCHOLOGICAL EVALUATION

NAME: Joey Lister
CASE NO.: 172897
AGE: 12
BIRTHDATE: 10/1/63
COUNTY: Baldwin

WARD: Children's 1 South
REFERRED BY: Dr. Gutierrez
ADMISSION DATE: 5/18/70; 9/18/72
EXAMINATION DATE: 7/8/75
DATE OF REPORT: 7/9/75

BACKGROUND: Joey Lister has been a patient in the Children's Building for a period of approximately five years. He has been a severe behavior problem during most of his stay. Joey's behavior appears to be somewhat cylical with periods of relatively appropriate behavior interspersed with severe acting out which manifests itself in aggression and hostility toward others. On September 8, 1972, Joey was furloughed to his foster mother. Shortly after his furlough, Joey became a discipline problem in school, and he was apparently unable to adjust to the home situation. Joey was re-admitted on September 18, 1972. Joey has an extensive history, and further medical, psychological, and social reports are available in the ward chart.

INTERVIEW DATA: Joey expressed considerable anxiety about his relationship with his parents. He stated, "I know their names, but I don't want to know them. I don't talk about them anymore." When asked about his father, Joey said, "I never seen my real father." He then hid his head and began to cry. Joey feels that his natural parents "gave him away." Judging by his attitude and behavior, Joey has considerable repressed anger and emotional pain concerning his relationship to his parents. Joey also refused to discuss his relationship with his foster parents although he did indicate that he felt rejected by them.

Joey's main concern during the interview was his hope of leaving the Children's Building for foster home placement. Joey stated that he believed he could behave if he were placed outside the hospital. He is fearful that this placement may not occur and avoids thinking about it.

BEHAVIORAL OBSERVATIONS: Joey came to the testing and interview sessions neatly dressed and displayed good personal hygiene. He was very active during the testing session, grabbing test materials, and walking around the room inspecting various objects and books on the shelves. Joey eventually settled down after some coaxing, and he was generally cooperative with the examiner. He was negativistic at times during the testing. Joey was easily frustrated by tasks which he felt were too difficult or [illegible] frustration [illegible] and [illegible] testing. [illegible] signs of [illegible] of bizarre symptoms associated with psychosis.

TESTS ADMINISTERED: Wechsler Intelligence Scale for Children - Revised (WISC-R), Bender Gestalt Test, Sentence Completion, Draw-A-Person (D-A-P), Blacky Picture Series.

TEST RESULTS: On the WISC-R, Joey achieved a Verbal IQ of 72, a Performance IQ of 101, and a Full Scale IQ of 84. The Full Scale IQ places him in the Dull normal range of intelligence. Joey seemed to be easily frustrated on this test and gave up on tasks that he felt were too difficult for him. Joey preferred the performance subtests and generally would not put forth the same effort with verbal tasks. His verbal score may be somewhat below his actual capability because of his low frustration tolerance; however, the examiner feels that he is handicapped by a lack of verbal skills such as associative thinking, verbal comprehension, and the utilization of abstract concepts in solving problems. His low vocabulary score suggests that his quality of language and richness of ideas is below average. His intellectual strengths seem to be his perceptual sensitivity, attention to detail, and concentration. Joey is alert to social cues in his environment and he has the capacity for appropriate responses to social situations. He also exhibits at least average ability for perceptual analysis and synthesis, with adequate nonverbal concept formation.

EXHIBIT #5-A-1

Psychomotor testing indicated that Joey's visual-motor maturation is age appropriate. There was no suggestion of central nervous system dysfunction.

Personality testing revealed that Joey has deep feelings of inadequacy, probably resulting from the insecurity and emotional deprivation of his childhood. Joey has many infantile needs which were not met in his childhood. These needs are still very much with him and require restitution. Joey has a very pessimistic outlook of his world although outwardly he tries to maintain an appearance of hope and optimism.

Joey expresses strong unresolved conflicts concerning his relationship to his parents which he attempts to blot out of consciousness. These are extremely painful areas of thought and feeling that he is fearful of confronting. There are some developed fantasies about "killing mother or dad" which is a way of attempting to deal with his anger and hurt. One of the important goals of therapy with Joey would be to establish a therapeutic relationship to assist Joey in expressing some of these repressed feelings of anger and hostility.

SUMMARY AND RECOMMENDATIONS: Joey is an insecure, emotionally starved child who is experiencing deep feelings of inadequacy and hopelessness. He has repressed some very powerful feelings of rejection and hostility. Joey needs a warm secure relationship with adult parent figures who will be able to cope, at first, with his excessive demands for their attention and affection. His fear of being rejected again is extremely strong and it will require time and patience before his excessive demands will subside. He is in need of continued psychotherapy to assist him in ventilating his repressed feelings and to help provide some stability. Continued hospitalization would not provide the emotional climate necessary to meet Joey's needs. It is my recommendation that Joey be considered for foster home placement with continued outpatient therapy. Potential foster parents should be counselled and clearly informed concerning Joey's needs and specific problems.

Ryan Lincoln, Psychologist
Children and Adolescents Unit

Marilyn Edmistion, Ph.D.
Clinical Director, Psychology
Children and Adolescents Unit

cc: Ward Chart, File.

EXHIBIT #5-A-2

EXHIBIT #6

A. Juvenile Court Petition - Baldwin Department of Family and Children Services

B. Report Accompanying Petition

C. Juvenile Court Order Granting Temporary Custody to Department of Family and Children Services

[illegible] COURT [illegible]

IN THE [illegible] COURT [illegible] COUNTY, [illegible]

In the [illegible]

Joe Mack Lister Jr.

Children [illegible]

TO THE [illegible] COURT, [illegible]

The Petitioner, Mrs. [illegible], respectfully [illegible] the following facts:

That the child [illegible] forth in the caption. [illegible] Lister Jr., [illegible] where she resides in [illegible] Park, [illegible] County, [illegible] parents. Said child [illegible] of Central [illegible] Central State Hospital [illegible], said mother.

2.

Said child was [illegible] Central State Hospital [illegible] because child's [illegible]

EXHIBIT #G-A-1

temper tantrums and [illegible] child [illegible] to function in the public school [illegible] system [illegible] as a [illegible] to function [illegible] setting, said [illegible] neighbors whose children had [illegible] harmed by said child. [illegible] and present [illegible] of said mother, [illegible] worked with Central State [illegible] approximately three years trying to learn to deal with said child and his [illegible] progress in his behavior at Central State Hospital he would be sent [illegible] mother and his [illegible] said mother [illegible] personnel and [illegible] the only [illegible] for the child. [illegible] another living arrangement [illegible] appropriate [illegible] for this child. Said [illegible] to Central State Hospital [illegible] 1976. [illegible] contact [illegible] time.

[illegible] said child's adoptive parents, were divorced in [illegible], when said child was three years of age. Said adoptive [illegible] has had no contact with said child for the past several years [illegible] contributed no financial [illegible] to this child. [illegible] support [illegible]

BEST COPY AVAILABLE

[illegible] custody of said child [illegible] Jack Lister Jr. be placed with [illegible] County Department of [illegible] and Children Services. [illegible] that said parent be ordered to pay an appropriate [illegible] amount [illegible] said child.

Petitioners pray that process issue [illegible] hereto requiring them [illegible] dealt with according to law.

[illegible]
Petitioner

Subscribed and sworn to before me, on information and belief this ___ day of [illegible]

[illegible]
Notary Public, [illegible]

Baldwin County Department
of Family and Children Services
By: Anne G. Etheridge Caseworker II
November 10, 1975

Lister, Joe Mack Jr.
Child in Central State Hospital
Children's Building

CIRCUMSTANCES INVOLVING RECEIVAL OF CHILD TO AGENCY

In November of 1973, Our Agency was contacted by Carolyn Grant, social worker in the children's building at Central State Hospital concerning the above named child. After giving some background on the child's situation she stated that Mrs. Sherwer wanted to relinquish custody of Joey to our agency and requested that I talk with Mrs. Sherwer about this possibility. In early December I talked with Mrs. Sherwer and we discussed the different ways that custody be relinquished to our agency. Mrs. Sherwer stated that she had been working toward her decision of relinquishing custody of Joey for approximately a year and a half.

In January of 1974, I discussed with Mrs. Sherwer the process that our state office would require for us to take custody of this child. Mrs. Sherwer and her ex-husband, Dr. Lister, were requested to petition the court to have custody of Joey given to our Agency. We agreed to take temporary custody of this child and requested that a support clause be included in the court order. In May of 1974, we received a copy of a document signed by Mrs. Sherwer and Dr. Lister, attempting to relinquish custody to Central State Hospital. This paper was notarized by a notary public, but did not have the signature of a Judge. Colonel Schuyler, legal advisor to Central State Hospital, stated that Central State Hospital could not take custody of a child as they are not a child placing agency.

Since this incident in the spring of 1974, we have been in contact with Mrs. Sherwer's lawyer and have tried to make it clear that we were

requesting that the parents of the child petition the court to give us temporary custody.

On October 30, 1975, Judge Owens of the Federal Court ordered that a petition be presented to the Juvenile Court of Baldwin County by 5:00 P.M. on October 31 or he would sign a statement placing custody of Joey with our Agency. Our legal advise was that this action by the Federal Court Judge would only complicate matters of custody further, so a petition and an order giving us temporary custody of Joey was presented to Judge Jackson and signed by him on October 31, 1975.

BACKGROUND AND CURRENT STATUS

Joey was adopted as a young infant by Mrs. Carrie Lister Sherwer and Dr. Joe Mack Lister Sr. The marriage of his adoptive parents was a turbulent one and ended in divorce in 1966. It was in the divorce decree that Joey would live with his mother, but Dr. Lister was ordered to pay child support and was allowed visiting privileges. This decision was handed down in the Superior Court of Tift County. Although Dr. Lister has not supported and has fulfilled no parental responsibilities towards this child, this order has remained unchanged. The rights of neither parent have been terminated and at the present time there are two legal parents involved with Joey's custody; his mother, Mrs. Sherwer, and his adoptive father, Dr. Lister.

Joey was admitted to Central State Hospital in May of 1970, by his mother. He had become too much of a problem for his mother to manage at home. Joey was having problems in school and also within the neighborhood. At the time of his admission his behavior was described as "extremely agressive with no regard for authority". One of Joey's

teachers described him as a "very hyperactive child who over-reacts to all situations." Joey's mother had remarried one year before Joey was admitted to Central State Hospital. The step-father, Jon Sherwer, seemed to be patient and understanding with the child's problems and showed great concern for this child. At one point Mr. Sherwer talked of adopting Joey. Mr. and Mrs. Sherwer worked closely with Central State Hospital attempting to understand Joey's behaviour and to learn ways and methods of dealing with the behavior so that Joey could live at home. They took him home for the week-end visits, for vacations and so forth, but his behavior did not seem to be improving. According to Mrs. Sherwer, she and her husband arrived at the decision with Central State Hospital that Joey would never be able to function in their home in 1972. However she stated that it took her about a year, and a half to make a definite decision about relinquishing custody of Joey. It was not until the time when this decision was made that our Agency became involved in this case.

In 1973, when we became concerned with the custody question of this child, we were also requested by Central State Hospital, specifically Carolyn Grant, social worker and Betty Harris, R.N. (Joey's primary therapist) to find another living arrangement for Joey. We discussed, on many different occasions, what type of foster parents or institution would be able to cope with Joey. A report dated August 1973, was sent to us. This report stated that Joey was going into his fourth year of hospitalization at Central State Hospital and "he continues to be a severe behavior problem." It was also noted that Joey's attitude towards himself tends to be rather punitive and that his self-confidence is very low. It was agreed that if a very special family could be found who would be willing to try to cope

EXHIBIT #G-B-3

with these problems that Joey might possibly succeed in a foster home placement. However this family was going to have to be a very "special" one, as it was recognized that Joey would require an extreme amount of attention and care. Foster families with children who are nearer "normal" are very hard to find and foster parents who are willing to even try to cope with a child such as Joey are almost impossible to locate. Our Agency was also concerned with Joey and his many failures with his family life. We felt that we should be very careful before another placement with Joey was made as he would see the failure of a foster care placement as another rejection and failure for him personally. Our department cannot pay for institutional foster care unless a child is an AFDC child and then it can pay only under certain circumstances. Joey is not an AFDC child.

RECOMMENDATION

Our Agency is willing to accept temporary custody of Joey but because of the financial situation we would need child support to help us arrange for the specialized care that this child needs.

Our Agency will seek a specialized home for Joey outside our area as we do not have a suitable home in this area. Even though we realize that this child may not be able to function outside Central State Hospital, we are willing to try to see if a placement will work for him. If another institution is available or recommended we would be willing to make the appropriate referral and attempts to get him into such an institution. However, again we will emphasize that financial support will be needed for us to do this.

EXHIBIT #G-B-4

GEORGIA, BALDWIN COUNTY

IN THE SUPERIOR COURT OF SAID COUNTY AS A JUVENILE COURT

The above petition having been read and considered by this court, the court has determined that the filing of this petition is in the best interest of this child and the public:

IT IS, THEREUPON, ORDERED that each of the above named partied be and appear before this court at the Courthouse Milledgeville, Ga on the 12th day of November, 1975 at 10:00 o'clock, AM then and there to show cause why the child named in said petition shall not be dealt with in accordance with the provision of law in such case. It is further ordered that temporary custody of said child be placed with the Baldwin County Department of Family and Children Services until the above hearing date. It is also ordered that a true and correct copy of the petition and process be served upon the parents, guardian, or other person having custody, control, and supervision of said child named in the petition.

This 31st day of October 1975.

George J Jackson
Judge Baldwin Superior Court acting as Judge of Juvenile Court

The above hearing has been continued because of lack of service on Joe Mack Lister SR. It is further ordered that temporary custody of said child be continue in the Baldwin County Department of Family and Children Services until further order of this Court.
This 12th Day of Nov. 1975 George J Jackson Judge

EXHIBIT #7-C

EXHIBIT #7

A. Admission Record

B. Inter Office Correspondence from J. T. Harris

C. Admission Summary

D. Application for Voluntary Admission

E. Representation Form

F. Personal History and Treatment Permit

G. History of Mental Illness

H. Psychiatric Examination

I. Inter Office Correspondence Re: M.R.

J. Admission Note

K. Diagnosis

ADMISSION RECORD

DATE _____

DESCRIPTION: AGE 7 HEIGHT 51 WEIGHT 56 TEMP 99 PULSE 72 B/P 84/62 RESP 20

ATTITUDE TOWARD ADMISSION: FEAR ____; WILLING X COMBATIVE ____ WITHOUT UNDERSTANDING OF WHAT IS HAPPENING ____;

PHYSICAL: AMBULATORY yes WHEEL CHAIR no STRETCHER no CRUTCHES no;
GAIT: STAGGERING ____ ODOR OF ALCOHOL no ODOR OF PARALDEHYDE ____ BLIND ____;
PUPILS UNUSUALLY ENLARGED ____; OR UNUSUALLY SMALL ____ COLOR OF EYES Blue;

CLOTHING: WELL ARRANGED ____; DISARRANGED ____; CLEAN X SOILED ____;

SKIN: UNUSUALLY PALE ____ FLUSHED ____ UNUSUALLY MOIST ____; UNUSUALLY DRY ____;
CLEAN ____; SOILED ____; WAS PATIENT GIVEN A BATH? ____; TYPE ____; SCARS none (Chart);
SCRATCHES ____; BRUISES ____(Chart); SCABES ____; PEDICULI PUBIS ____; CUTS none;
BURNS ____; ERUPTIONS ____; DECUBITUS ____;

HAIR: WELL-GROOMED yes; DISARRANGED ____; MATTED ____; COLOR OF HAIR Red; CLEAN yes;
SOILED ____; EVIDENCE OF PEDICULI ____; HEAD TREATED FOR PEDICULI ____;

ORIENTATION: CAN GIVE NAME yes; KNOWS WHERE SHE IS yes KNOWS APPROX. DATE yes;

PERSONAL POSSESSIONS: JEWELRY none; MONEY ____; VALUABLE PAPERS ____; DESCRIBE THESE THREE ITEMS ON BACK OF SHEET. GLASSES ____ TYPE ____ DENTURES ____;
FULL OR PARTIAL ____; BRIDGE ____; DOES PATIENT HAVE PERMISSION TO USE PERSONAL BELONGINGS yes

MENTAL STATE: DOES NOT ANSWER QUESTIONS yes; DOES NOT SEEM TO UNDERSTAND QUESTIONS ____;
TALKS VERY LITTLE yes; OVERTALKATIVE ____; IS TALK MEANINGFUL ____;

EMOTIONS: UNWARRANTED FEAR ____; EXPRESSIONS OF HATE ____; TOWARD WHOM ____; IDEAS OF PERSECUTION ____; BY WHOM ____;

IDEAS: STRANGE EXPRESSED THOUGHTS (explain) ____

COMPLAINTS: (any expressions of physical or mental nature)

LEGAL:
(Add any pertinent information on back of sheet.)

TRANSFERRED:

PATIENT RECEIVED BY: Miss Kennedy Psy Tech CHECKED BY: Miss Kennedy Psy Tech
SIGNATURE SIGNATURE

RAMEY, JAMES LAMAR
173617 WH 54 8-14-62
6-25-70 127

SOCIAL SERVICE DATE:

CLINICAL ADMISSION RECORD

EXHIBIT #7-A

CENTRAL STATE HOSPITAL

Georgia Department of Public Health

INTER-OFFICE CORRESPONDENCE

TO: ALL ADMISSION EMPLOYEES DATE 6-24-70

FROM: J. T. Harris

SUBJECT: James Lamar Raney

James Lamar Raney, AGE: 7, Stephens County is to be admitted to this hospital soon. Requested by Colonel Schuyler. He is emotionally disturbed.

JTH:ldl

EXHIBIT #7-B

ADMISSION SUMMARY

Hospital: CENTRAL STATE HOSPITAL

(Last)	(First)	(Middle)	(Maiden)	173,417
RAMEY,	James	Lamar		?

Date of Admission	Type Admission	Type Commitment	Ward	Type of Service
6-25-70	1st	54-Vol	Children's Unit 1 S	In-Patient

Address (Present No. and Name)	(City)	(County)	(State and Zip Code)	Place of Residence	Telephone #
Department of Family & Children Services,	Toccoa,	Stephens,	Ga.	?	?

Race and Sex	Age	Birth Date	Birthplace (City, County, State)	U.S. Citizen
White Male	7	8-14-62	Stephens County, Ga.	Yes

Nearest Relative (Name)	Relationship	Address	Telephone No.
?	?	?	?

Person Having Legal Custody or Guardianship	Address	Telephone No.	Child Lives With
?	?	?	?

Person To Notify in Emergency	Relationship	Address (Home and Work)	Telephone No.
Barbara C. Carpenter Child Welfare Counselor	None	Dept. of F&CS, Toccoa, Ga.	?

Patient's Nearest Relatives (Name)	(Street No. and Name)	(City, State and Zip Code)	(Relationship)	(Telephone No.)
1st Barbara C. Carpenter	Department of F & CS	Toccoa, Ga.	Counselor	?
2nd				

Marital Status	Number of Children	Education (No. of Years)	Employed or Retired	How long employed	Patient's Occupation	Spouse's Occupation
Single	0	1	N/A	N/A	Student	N/A

Name and Address of Employer (Patient)	Name and Address of Employer (Spouse)
N/A	N/A

Last Day Patient Worked	Annual Income Patient	Annual Income Family	Receives Social Security Benefits	Health Insurance Number
N/A	None	?	No	?

Veteran	C or Serial Number	Receives Military Benefits (Including VA)	Receives Welfare Benefits	Receives Child Benefits
No	N/A	N/A	Yes	?

Hospital Insurance	Policy No.	Group No.	Insurance Company (Name and Address)
No	N/A	N/A	N/A

Religious Preference	Name and Address of Church
Protestant	?

Father's Name	Birthplace	Living	Age	S.S. Number	Veteran	Religious Preference
Joe Ramey	?	Yes	47	?	?	?

Mother's Name	Birthplace	Living	Age	S.S. Number	Veteran	Religious Preference
Eugene Ramey	?	Yes	41	?	?	?

Family Physician (Name and Address)

2

Referring Agency (Name and Address)

Stephens County Department of Family & Children Services

Admitting Clerk: JMC

Time Admitted: 2:30 XXX P.M.

Admitting Diagnosis (Mental and Physical)

Emotionally disturbed.

No. Days	Movement Date	Movement Unit	Movement Modality

Final Diagnosis

1. Borderline mental retardation 310.90
2. Unsocialized, Aggressive reaction of childhood 301.70

Condition

Prognosis

EXHIBIT #7-C

GEORGIA DEPARTMENT OF PUBLIC HEALTH
APPLICATION FOR VOLUNTARY ADMISSION TO
Central State HOSPITAL

(By Authority of Section 88-501.1, Georgia Health Code, Ga. Laws, 1969, pp. 505-545)

James Lamar Ramey, Age 7
(Type or Print Full Name)

residing at in custody of State Department of Family & Children Services,
(Street Address)

Supervision by Stephens County Department of Family & Children Services,
(City) (State) Toccoa, Georgia

(County) request admission to Central State Hospital on a voluntary basis and hereby agree to abide by the rules of the Hospital (see back of page) and to leave the Hospital willingly when informed by the medical staff that I no longer need to stay.

Signature

Witness

Title

Address

NOTE: Parent or guardian must sign below if applicant is under 18 years of age, or under 14 years of age if admission to an Evaluating Facility is desired, or by Guardian if applicant has been adjudged legally incompetent.

As parent or guardian of the above named individual I agree to all of the provisions of this application.

Barbara C. Carpenter, Child Welfare Co
Signature of Parent/Guardian

June 24, 1970
Date

Witness Gladelle M. Whitaker

Title Notary Public

Address P.O. Box 427
Toccoa, Ga.

STEPHENS COUNTY DEPARTMENT OF
FAMILY AND CHILDREN SERVICES
TOCCOA, GEORGIA

Gladelle M. Whitaker, Notary Public, State of Georgia. My Commission Expires June 10, 1972

☒ Family History record included

☐ To Follow by Mail

EXHIBIT #7-D-1

MH 1[illegible], Section 88-501.1] Georgia Department of Public Health

_______________ Hosptial

RULES AND REGULATIONS FOR VOLUNTARY ADMISSION TO _______________ HOSPITAL

1. For voluntary admission, arrangements must be made with the Superintendent or his representative in advance of coming to the Hospital for confirmation of availability of beds. This may be done by telephone or in writing.

2. When admitted on a voluntary basis, a patient agrees to submit to all of the rules and regulations of the Hospital.

3. For a voluntary admission, a patient must have sufficient mental clarity to be responsible for and willingly sign the Application for Voluntary Admission.

4. For a voluntary admission, a patient must recognize the nature of his condition and the purpose for which he is admitted.

5. A patient will not be accepted on a voluntary basis when criminal charges or indictment are pending against said patient.

6. When admitted on a voluntary basis, a patient agrees for the doctors at the Hospital to administer any type of standard treatment deemed advisable.

7. A voluntary patient may request a discharge from the Hospital by addressing the Superintendent in writing in accordance with Section 88-503.3, Georgia Health Code, Ga. Laws, 1969, pp. 505-545.

NOTE: Any item in question which is not covered in the above rules and regulations may be directed to the Division of Mental Health, Georgia Department of Public Health, the hospital, your local health department or your local physician.

EXHIBIT #7-D-2

June 25, 1970
(DATE)

James Lamar Rapley
NAME

173617
HOSPITAL NUMBER

C El 1 South
WARD

[illegible] patient [illegible] family - He is a ward of DFCS and they are the only one to be notified - we were not able to get a history due to the

1st REPRESENTATIVE: Barbara C. Carpenter
NAME

Child Welfare Counselor
STREET ADDRESS

Dept of Family and Children
CITY STATE

Services - Toccoa, Ga.
ZIP CODE

Please check phone book for correct number → Phone 806-

2nd REPRESENTATIVE: _______________
NAME

____
STREET ADDRESS

____
CITY

____
ZIP CODE

1. Patient's Legal Guardian
2. Spouse
3. An Adult Child
4. Parent
5. Attorney
6. Adult Next-of-kin
7. Adult Friend

EXHIBIT #7-E

PERSONAL HISTORY AND TREATMENT PERMIT

CENTRAL STATE HOSPITAL
MILLEDGEVILLE, GEORGIA

Please Answer All Questions

Patient's Name: Mr. ~~Miss~~ ~~Mrs.~~ Ramey, James Lamar
Last, First, Middle and Maiden

Hospital Case No. 173617 (Supplied by hospital after admission) Date of Admission: 6-25-70 County: Stephens

Age 7 Race W Date of Birth: 8-14-62 Social Security No.

Place of Birth: Stephens Co. How long a resident of Georgia Life

Legally (court appointed) Guardian: Name Address

Guardian of Person Property Both

Address of pt. prior to admission: Stephens Co. DFCS Toccoa, Ga. 3057
Street City Zip Code

Give Name and Relationship of Other Adults in Household:
Name Relationship
Harold Satterfield (foster father)

Are there any drugs to which patient is allergic? (Name them)

If patient is presently taking any types of medication, please list: Dilantin

Patient is Single ✓ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ How long

If the patient has been married before, give the following information for each marriage

Name Age Years married

With whom will patient live when he leaves hospital? age address
Barbara C. Carpenter, Social Work DFCS.
Name and address

Who is the patient's principal occupation? Student

Did the patient work regularly in the last year? None Average Monthly Income

EXHIBIT #7-F-1

If any persons on the patient himself, are working and have contributed to the patient's support, give following information.

State + County Funds
Name Relationship Principal Occupation Avg. Monthly Income

Does the patient receive income from any of these sources: (Underline)

Social Security, Welfare, Veterans' Administration, Railroad Retirement? Amount unknown

If patient is 65 years of age or older, is he/she signed up for Medicare?

Part A (Hospital) Part B (Medical)

Hospital Insurance Co. (Medicare)

If any person close to the patient receives income from these sources and shares this income with the patient, indicate following

Name Relationship Source Amount

Give highest school grade completed or degree received. Special Education

Give the following information on school attendance as indicated

Age Entered 7 Was Attendance Regular? Yes Grades Good or Bad? Satisfactory

Grades Repeated? Age Left School? Reason?

If the patient served in the Armed Services, give the following information:

Service Year entered Year left Type Discharge Service No. Service Occupation Claim No.

Is the patient active in church? Denomination? Protestant

If the patient was ever arrested, give the indicated information

Date Place Reason Disposition

Concerning the patient's parents

Father Age Occupation Education
Eugene Ramey #1 unknown

Mother Age Occupation Education
Mabel Purnell by remarried from family

Step-Parent Age Occupation Education

If parent(s) is deceased, give the age at death and cause

If the patient's parents ever obtained a divorce, give age of patient at the time

Give the following information regarding siblings, (includes those who may have died or who may be half-siblings):

Name Age Address Occupation (if deceased, give cause)

4 brothers + sisters adopted by DFCS

EXHIBIT #7-E-2

If the patient has been mentally ill before give the following information:

Approx. Dates of Illness — Physician or Hospital where treated & address

Has the patient ever used alcohol excessively? No Drugs? No

If any relative of the patient has been mentally ill, addicted to alcohol or drugs or been in a mental hospital, give the following information:

Brother + Father addicted to alcohol

Name — Relationship — Nature of Illness — Hospital, if hospitalized

Briefly, what about the patient's behavior makes you feel he needs hospitalization?

Did his behavior appear suddenly or gradually?

Check any of the following which describes the patient's behavior: Felt someone or something had special control over him, ___ Had fears of being harmed, ___ Heard imaginary voices, ___ Smelled peculiar odors, ___ Saw imaginary persons or things, ___ Thought they were someone else, ___ Experienced loss of memory, ___ Seemed to lose interest in people and things, ___ Neglected appearance, ___ Spoke angrily to others, ___ Was physically violent to self or others, ___ Depressed, ___

If the patient has been suicidal, homocidal, violent, or destructive, describe:

Describe any serious illnesses, injuries or operations as indicated

Illness, injury or operation — Date — Physician or Hospital where treated and address

If any relative of the patient or the patient himself has had any of the following illnesses, give the information requested below: Heart Disease, Asthma, Ulcers, Diabetes, Tuberculosis, Epilepsy or Fits, Syphilis, Cancer, Huntington's Chorea, Wilson's Disease, Pick's Disease

Patient — Epilepsy

Name — Relationship — Describe Illness

One Aunt — Heart Condition

Two Uncles — Mentally retarded

Has the patient ever had convulsions, fits, blackouts, or epilepsy? Seizures

Were these light or severe? Light How often did they occur? Frequent

Name, Address & Relationship of Informant: Barbara C. Carpenter (Social Worker) Dept. of Fam. + Ch. Serv., Toccoa, Ga. (Box 357)

PERSON TO NOTIFY IN CASE OF EMERGENCY: Same

Name

Address — Zip Code

Additional Remarks

Barbara C. Carpenter
Stephens Co. DFCS, Toccoa, Ga.

AUTHORIZATION AND TREATMENT PERMIT

Date 6-25-70

I, the nearest relative or guardian, hereby authorize the Superintendent or any Central State Hospital staff member whom he may designate to:

1. Give any recognized psychiatric treatment, including electro-convulsive therapy, and to perform any and all operations that may be necessary ...

2. ... physicians, social agencies or other professionally qualified ... information which they may desire that is recorded in the medical and psychiatric record of the patient when such would contribute to the treatment of the patient.

3. Arrange for public transportation home for the patient in the event that no responsible relative can come for him when he is ready for release from the hospital.

4. Permit patient to wear and use such personal items as: clothing, jewelry, false teeth, spectacles and I, the nearest relative or guardian, agree to assume full responsibility for the loss and destruction of such articles.

X James Lamar Ramey
Signature of Patient

Signature of Nearest relative or guardian

Arthur E. Johnson
Witness

C ... Dec. 1969

EXHIBIT #7-F-4

CENTRAL STATE HOSPITAL

HISTORY OF MENTAL ILLNESS

INSTRUCTIONS: INCLUDE (1) IDENTIFICATION, (2) INFORMANTS, (3) REASON FOR ADMISSION, (4) PRESENT MENTAL ILLNESS, (5) PREVIOUS MENTAL ILLNESS, (6) PERSONAL HISTORY, (7) FAMILY HISTORY.

IDENTIFICATION:

This is the first admission to Central State Hospital for this seven year old white male who was admitted on June 25, 1970. His birthdate is August 14, 1962. His occupation is that of student.

INFORMANTS:

Some material supplied by the Department of Family and Children Services of Toccoa, Georgia (Stephens County).

REASON FOR ADMISSION:

This patient has been destructive at home. His foster mother states that in May of 1970 he destroyed over one hundred canning jars during a fit of anger. He has "night attacks" and during these attacks he may run about the house apparently not fully conscious. During these attacks he has struck his head against the walls at times.

[illegible]

James was with his mother only three months. When he was three months old he was removed from his home due to neglect and a court order was issued giving the custody of the patient to the Department of Family and Children Services of Toccoa, Georgia (Stephens

CONTINUED ON REVERSE SIDE

RAMEY, JAMES LAMAR
173,617 WM 5½ 8-14-62
6-25-70 127
CHILDREN'S SERV. T

DATE
3-11-70

[illegible] HISTORY OF MENTAL ILLNESS

County). The patient was placed in foster care. Since this first placement he has had six different foster homes. Each time he seems to lose his place to a more favored child. Head banging began in his first foster home when he was eighteen months old and he was described as being very hard to manage. In October 1965 his temper tantrums were increasing and he was hospitalized on October 21, 1965 at Aidmore for an encephalogram and X-rays. All reports were negative. At that time he was screaming, spitting, and head-banging so much that he had to be sedated. He would not talk during his hospitalization. He has been in the last foster home since July 18, 1967 where, as mentioned above, he has been destructive and he had these so called "night attacks". For some time he was doing better but when he became a little fearful of his position in the family he revealed his jealousy, having temper tantrums and saying that "Mama was better to the girls than to me". Also, he started again wetting the bed. For one year James was the only child at home but lately one boy, fourteen years old, was placed at the foster home and he related well with this boy. Sometimes he was frustrated because the boy did not play with him all the time. This boy was moved on April 30, 1969 but on April 8, 1969, DeDe, age 8, and Terry, age 7, were placed in the foster home and James became jealous and fearful of his position in the family as mentioned above.

PERSONAL HISTORY:

[illegible] born to [illegible]

ounces. [illegible] came into foster care weighing eight pounds, four ounces, at three months of age. He sat alone at nine months and walked at about fourteen months of age. He began saying "Dada" and "Mama" at ten months of age. He continued in monosyllables until past his second birthday. He was weaned and toilet trained at two years of age. While in foster care he has had regular medical attention. Surgery for a right inguinal hernia was performed at Crippled Children's Clinic in October of 1964. James' health has been good. He has been treated for epilepsy but we feel that he has no epilepsy. His electroencephalograms have been negative more than one time. Immunizations are current. All dental [illegible] encephalogram [illegible] at General State [illegible]

EXHIBIT #7-G-2

CENTRAL STATE HOSPITAL

HISTORY OF MENTAL ILLNESS

INSTRUCTIONS: INCLUDE (1) IDENTIFICATION, (2) INFORMANTS, (3) REASON FOR ADMISSION, (4) PRESENT MENTAL ILLNESS, (5) PREVIOUS MENTAL ILLNESS, (6) PERSONAL HISTORY, (7) FAMILY HISTORY.

his physical examination was within normal limits, his chest X-ray was negative for T.B.

FAMILY HISTORY:

His father's present whereabouts are unknown. The father has a long record of drunkenness and conflicts with the law. The mother is living, her family has been recipients from the Department of Family and Children Services for many years. James has one sister and four brothers. Four of these children have been placed in foster homes. There is very good information about the family in the Summary of Life Experiences made by the Department of Family and Children Services. No history of T.B., asthma, diabetes, or epilepsy is in the family.

James was in school, doing quite well in the first grade class until the time his teacher retired and she was replaced in March by a much younger teacher. Then he became a disciplinary problem and created such a stir in the classroom that he disrupted activities. His pediatrician was consulted and James' dosage of Dilantin was increased in hopes of decreasing these destructive bursts of temper. The doctor also advised that

JR: mh

CONTINUED ON REVERSE SIDE

RAMEY, JAMES LAMAR
173,617 WM 54 8-14-62
6-25-70 127

DATE: 8-11-70

HISTORY OF MENTAL ILLNESS

EXHIBIT #7-G-3

CENTRAL STATE HOSPITAL

PSYCHIATRIC EXAMINATION

INSTRUCTIONS: Include (1) Date, duration and circumstances of interview, (2) Patient's description, including appearance and activity, (3) Interpersonal attitudes, (4) Speech and communication, (5) Affect, (6) Ideation, (7) Perception, (8) Orientation and memory, (9) Intellectual function, (10) Judgement and insight, (11) Provisional diagnosis.

The three interviews we had with the patient were in the library of the Children's Building.

DESCRIPTION OF THE PATIENT:

The patient is a seven year old white male, an attractive red headed child. He was willing to go with the examiner to the library for an interview. He was neat and clean. His gait was normal. His psychomotor activity was normal or within normal limits for his age. No mannerisms were elicited.

INTERPERSONAL ATTITUDES:

He was cooperative with the examiner. His attention span for things which interested him appeared to be adequate. He was able to look at page after page of a book with many pictures about the trip to the moon done by the astronauts. He knows how old he is.

The patient is able to answer questions. His speech is logical. His form of thought is questionable.

RAMEY, JAMES LAMAR
173,617 WM 54 8-14-62
6-25-70 127

DATE: 8-11-70

PSYCHIATRIC EXAMINATION

EXHIBIT #7-H-1

AFFECT:

His affect was appropriate.

IDEATION:

The patient does not show any overt psychotic ideation at the present. Dr. Griffin examined this patient in October 1968 and he stated that this patient has a chronic anxiety concerning whether he will be cared for. He feels anger about this and acts this out with aggressive behavior. We agree with this statement.

PERCEPTION:

There is no history of hallucinations.

ORIENTATION:

The patient knows the day but he does not know the month or the year. He knows he is in Milledgeville. His memory appears to be good.

INTELLECTUAL FUNCTION:

The psychological evaluation done on this patient reports that he has an I.Q. of 77 [illegible] that he is capable of functioning in the dull-normal range of intelligence [illegible]

PROVISIONAL DIAGNOSIS:

1. Borderline Mental Retardation, Code No. 310
2. Unsocialized, Aggressive Reaction of Childhood, Code No. 308.4

PREMORBID PERSONALITY:

Unknown.

EXHIBIT #7-H-2

CENTRAL STATE HOSPITAL

PSYCHIATRIC EXAMINATION

INSTRUCTIONS: Include (1) Date, duration and circumstances of interview, (2) Patient's description, including appearance a activity, (3) Interpersonal attitudes, (4) Speech and communication, (5) Affect, (6) Ideation, (7) Perception, (8) Orientation memory, (9) Intellectual function, (10) Judgement and insight, (11) Provisional diagnosis.

STRESSFUL FACTOR:

This boy has been, at seven years of age, in six different foster homes. He feel that this is a traumatic experience.

DEGREE OF IMPAIRMENT:

Mild.

RECOMMENDATIONS:

To keep the patient in the hospital. He will benefit from the structured environment. The patient whould be enrolled in school activities. He will enjoy living and playing with boys of the same age.

JR: mh

RAMEY, JAMES LAMAR
173,617 WM 54 8-14-62
6-25-70 127
CHILDREN'S BU[illegible]

SIGNATURE: [illegible] DATE: 6-25-70
[illegible] PSYCHIATRIC EXAMINATION

EXHIBIT #7-H-3

CENTRAL STATE HOSPITAL

Georgia Department of Public Health

INTER-OFFICE CORRESPONDENCE

TO: Admissions Office

FROM: Dr. Robert W. Wildman, Chief Psychologist

DATE 6-2 70

SUBJECT: Screening of underaged patients

NAME: James Lamar Ramey

AGE: 7

IQ:

☒ This individual is not retarded (IQ 70 or over)

☐ This individual is mentally retarded (IQ under 70)

COMMENTS:

[signature]

Psychology Technician

EXHIBIT #7-I

CENTRAL STATE HOSPITAL

ADMISSION NOTE

PRESENTING PROBLEM:

6/25/70 This is the first admission to CSH for this 7 y/o w/m Student

Special education class 1st grade

IMPRESSION:

Pt have been in a foster home since he was 3 month old

Pt is very destructive, can't tolerate any frustration

He was seen in the Mental Health clinic, Pt had been bed wetting, has crying spell at night

REMARKS:

R/: Adjustment Reaction of Childhood

[signature] III

ADMISSION DATE:	ADMISSION TYPE:
SIGNATURE:	DATE:
DATE OF BIRTH	MARITAL STATUS:

RAMEY, JAMES LAMAR
173617 WM 54 8-14-62
6-25-70 127

[illegible]

CSH 414 ADMISSION NOTES

EXHIBIT #7-J

CENTRAL STATE HOSP TAL

DIAGNOSIS

THI PATIENT WA PRESENTED TO THE WARD STAFF AND WAS GIVEN A DIAGNOSIS OF:

I agree with the diagnosis offered by Dr. [illegible] of:

AXIS I: 1. Borderline Mental Retardation, Code No. 317
2. Unsocialized, Aggressive Reaction of Childhood
309.0

AXIS II: Deferred.

AXIS III: This boy has been, at seven years of age, in six different foster homes. He found that this is a traumatic experience.

AXIS IV: Mild.

AXIS V: Fair.

RECOMMENDATIONS: To keep the patient in the hospital. He will benefit from the structural environment. The patient should be enrolled in school activities. He will enjoy living with [illegible] the boys of the same age.

TYPE OF ADMISSION:

SIGNATURE: [signature] DATE: 8-22-7

DIAGNOSIS

EXHIBIT #7-K

EXHIBIT #8

Court Order Giving Department of Family and Children Services Custody of J.R.

GEORGIA, STEPHENS COUNTY:

IN THE JUVENILE COURT IN AND FOR SAID COUNTY:

IN THE INTEREST OF JAMES LAMAR RAMEY, A WHITE CHILD, UNDER THE AGE OF SEVENTEEN YEARS:

JUVENILE COURT DOCKET NO: 211 - PAGE: 57

The above stated case coming on for a hearing on this date, all parties being present, after hearing the evidence the court finds from the evidence that the material allegations of fact set forth in the petition are true;

It is thereford ordered by the court that permanent custody of said child be and the same is hereby plac d in the Georgia Department of Family and Children Services for the purpose of placing said child f:· adoption.

This the 27th day of October, 1966.

Judge of Superior Court, presidi as Judge of Juvenile Court in an for said County.

EXHIBIT #8

EXHIBIT #9

A. Summary for Placement Resource

B. Stephens County Mental Health Clinic Records

RAMEY, James Lamar, b. 08-14-62
127-2789
Stephens County Child

Worker: Becky H. Turner, CWS I
Stephens Co. Dept. of
Family & Children Services
Date: 06-12-73

Summary for Placement Resource

James Lamar Ramey is an attractive enough child, with an appeal about him and a genuine yearning for consistent, dependable love. In that, he is not so different from most children, but he is different from many in that he has never had really consistent love - never been able to develop any security or self-esteem. He is an average sized ten year old boy with a lean build. His brownish red hair is long enough to fall across his forehead. He has very fair, freckled skin, blue eyes, and fairly even teeth.

Jimmy has been at CSH since 06-25-70, after many foster home failures, following a very poor initial natural home and initial foster home experience, as an infant. In fact, Jimmy has reflected well, regrettably, what effect poor early maternal nurturance can have.

Our department became aware of Jimmy in November, 1962. The department was given temporary custody of Jimmy when he was three months old. He was removed from his natural family after it was discovered that he was badly malnourished. Later, Jimmy's other siblings were removed from the natural family and after the parents were unsuccessful in making any necessary improvements, following removal of the children, parental rights were terminated. Jimmy's five brothers and sister were all placed for adoption and the plan has been that the siblings not keep in touch. Jimmy does not have any ties with his natural family.

The natural father had a drinking problem but did work. His usual occupation was as a laborer or truck driver. However, he never used his earnings to support the family. The natural mother, of limited intelligence, was completely inadequate as a parent. Both she and the father were in rather consistent conflict with the law.

Jimmy's first foster parent was a widow. There was another infant in the home, as well as a young toddler and two other children. Jimmy remained there for about two years, until November, 1964. A succession of infants were boarded by the foster parent and as new infants were boarded, attention was focused on the new infants. It was felt that Jimmy suffered a lack of stimulation and lack of attention. Having been neglected already in his natural home, Jimmy began to show emotional symptoms at an early age.

On coming into care, Jimmy had a right inquinal hernia and a slight orthopedic problem. He "toed in". Before placement for Jimmy could have been considered, efforts were made to correct his medical problems and help him catch up to his proper developmental level. Surgery followed for the hernia and a Dennis Brown Splint was used for the orthopedic problem.

EXHIBIT #9-A-1

cont'd When the child was much less than two years old, he began "head banging". He was placed in a second foster home just prior to his surgery, and as emotional symptoms increased following the surgery, the foster parents decided they could not cope and asked that Jimmy be removed. Jimmy was seen by the doctor for nervous symptoms while in the second home. Then he was hospitalized in Aidmore just prior to removal from his third foster home. At that time he was "head banging, spitting and kicking", and again the foster parents felt they could not continue to keep him.

Jimmy made a good improvement in his 4th foster home. In fact, he was beginning to act like a normal child. However, the foster mother developed a health problem requiring surgery, the couple's financial situation became strained as well, and they had to ask that their home be closed. Jimmy was moved to his 5th foster home.

He had been tested psychologically as an infant and again while in his last foster homes. There was much consultation and effort by the 4th foster parents to follow medical advice, though Jimmy was not involved in actual treatment or therapy. Jimmy's first test results placed him in low average intelligence range. However, later testings have not been so good, as Jimmy's insecurity and lack of motivation has grown.

In his last foster home before placement in CSH, Jimmy adjusted satisfactorily and was the only foster child for a year. Older siblings were placed in the home but did not seem to threaten Jimmy's position. Two young girls were then placed after the older children were moved. Though thrilled over having other children to play with to begin, Jimmy's jealousy began to grow. After a stormy period, marked by tantrums and bedwetting, Jimmy adjusted satisfactorily. During this time he was seen regularly at a local Mental Health Clinic. He also attended Headstart. When he entered the 1st grade, Jimmy did alright until his teacher retired and was replaced by a younger teacher. He then became such a disciplinary problem and was so disruptive in class, screaming, fighting,' pushing over desks, and so forth, that he could hardly be contained. He was on Dilantin medication and this was increased, but not with very significant results. At home Jimmy was bedwetting, distructive and again unable to stand competition from other children. He regressed in social manners and even had one episode of smearing feces. The foster parents finally reached the decision that they had done all they knew to do for Jimmy and asked that he be moved at the end of that school year (1970).

Jimmy's placement at CSH has seemed to be his most profitable placement yet. He has not been the extreme behavioral problem while there, that he has often been in the past. That has to indicate improvements. However, as is often the case, just because he has not been as much of a behavioral problem as at times in the past, is not felt to be indicative that CSH is the place for Jimmy to stay. On the contrary, CSH has for some months been requesting a long-term foster or adoptive home for Jimmy. It is felt that Jimmy will now only regress if he does not get a suitable home placement, and as soon as possible.

EXHIBIT #9-A-2

cont'd

Jimmy is in good physical health. A systolic heart murmur was found in 1970 but no pathology was evident and Jimmy's activities are not limited. Jimmy is up to date on immunizations and has had the following since admission to CSH: Tetanus Toxiod 7-2-70 and 9-2-70; Rubella Vaccine 7-14-70; Mumps Vaccine 1-12-71; Oral Polio immunization 11-18-70; and negative Tuberculine Tine Test 7-2-70. Blood testing (CBC) was performed 1-18-73 with results normal. Yearly physical exam also was normal. Jimmy had an electroencephalogram 7-1-70 with normal results. Recent dental check on 2-5-73 showed some dental cavities. Teeth were cleaned and restored.

CSH reports that Jimmy's school work in his special education class has been satisfactory. Consistent discipline has helped Jimmy to adjust. It is still recommended that he continue in special education on the primary level. Jimmy presently functions at about the 2nd grade level with slightly lower reading skills. He continues to show a low tolerance to frustration. He frustrates easily because he seems to be a "perfectionistic" in his performance, according to his teachers at CSH. Jimmy reacts, when frustrated by too difficult a task, by pouting, destroying his work, or crying. He can also have temper rage, still.

Jimmy has had many psychological tests in the past, including at least three while at CSH. His latest testing was on 12-22-71, and on which he obtained his lowest score, I.Q. 61. Previously, he had scored at 65 or 77 on I.Q. The discrepancy is associated with the differences in motivational levels at the times of testing.

The staff at CSH conclude that Jimmy is a mildly retarded child who has displayed an Unsocialized Aggressive Reaction of Childhood. Presently, his motivation seems to drop lower and lower. He frequently asks when he can go home - though he has displayed that he has no clear concept of who his parents are - how could he? In his anxiousness to have a home, Jimmy has made up fantasies, saying to others that he was going home with his parents in a few days.

Jimmy has visited in foster homes on holidays, and efforts have been made to no avail to develop a placement for Jimmy in his home county. Jimmy always wants to stay, when leaving a home after a visit. He has behaved rather well on these visits and remarked after the last, that he wished he could live with the foster family forever.

Current apparent behavioral deficits are short attention span, low frustration to tolerence, occasional enuresis, and lack of motivation to achieve. As previously stated, he can throw a temper tantrum. Jimmy has shown improvements and does function better than before.

As Jimmy's Social Worker at CSH has pointed out, Jimmy's main problem is that he has no parents and no past successes. It is felt that nothing would benefit Jimmy quite so much as closeness of relationship on a consistent basis. Jimmy needs structured support and freedom to "express negative feelings in a non-threatening atmosphere." He needs firm but compassionatediscipline and needs only expectations that he can "realistically" fulfill. Jimmy will have to have acceptance from authority figures. Due to his past failures, Jimmy has come to expect to fail. Prospective parents must have tolerance to accept initial "acting out".

EXHIBIT #9-A-3

Social Workers at CSH feel very strongly, as do we, that many factors indicate that now is the crucial time to place Jimmy, if he is ever to have another family home placement. Jimmy has received maximum benefit from Central State's program. He has turned ten and is not far from adolescence, and doubtless, if he is not placed before adolescence, he cannot be expected to adjust at that difficult time.

It has been brought out as "critical" that a home found for Jimmy not be one that is filled with other siblings, but one that would offer a long-term relationship with mature parents, possessing the insight to understand Jimmy's dynamics. The parents would have to be willing to give of themselves to meet Jimmy's needs. Finally, if possible, the parents should have opportunity for family counseling. CSH has offered to arrange for some such sessions. The parents would need to establish some type of behavior modification techniques, such as those to which Jimmy has been responding at CSH.

We do not know if such a home is available, or consequently, if this child will ever get a chance for consistency in a family home and the benefits it could provide him - but we desperately hope so. Only Jimmy wants that more so.

EXHIBIT #9-A-4

James Ramey leveland, Ga. (Stephens Co. D.F.& C.S.)

Case No.: 329

Date of Admission: 5-22-69

No. of Previous Admissions:

Date of Last Termination:

Aftercare
5-22-69
James Ramey was in for his appointment. Worker talked first with James and his foster mother, Mrs. Satterfield, together, then talked with Mrs. Satterfield, and the caseworker, Mrs. Bracewell, while James waited for us outside.

James is quite an attractive youngster although he was obviously very insecure. He was so timid and shy he would hardly answer even simple questions, but would look to his foster mother to answer for him. There is quite an adequate social history provided for us by the Family and Children Service who referred the child to our agency, so worker spent most of his time discussing some of the current problems that concern the boy.

He is obviously an angry child. The mother seemed amazed that he delighted in spending long periods of time simply knocking down and beating up old corn stalks. He likes to throw rocks and will spend long periods of time cutting up paper when permitted to do so. Worker tried to help her gain some insight into some of the contributing factors to the child's anger and discussed with her ways of helping him learn to express it in a controlled, safe fashion, emphasizing the child's need to learn to feel accepted even though he is an angry person. She also discussed his obvious negative self-image. When he first came to the home, he would announce to the company who came in that he peas in the bed. She finally has gotten him to cease this kind of behavior, but he still wets the bed. Sometimes he will go for a while without doing so but recently has been wetting the bed every night. Upon one occasion he told her he was going to. She found the bed wet before he had ever been to sleep. She spanked him for this, but generally does not react in this fashion. She has essentially tried to ignore it as though it didn't matter. This is not working. Worker suggested she continue to be understanding about it and not take punitive action, but at the same time to let the child know that it is an unpleasant thing and that she really doesn't like changing wet beds.

James also seems to be a bit compulsive, from her description of his behavior, about leaving everything in order. She mentioned that when he plays he has to line up his toys in a perfect line, and that if he attempts a task and cannot complete it to his satisfaction, he becomes very frustrated, such as bed-making. He cannot tolerate a wrinkle left. Worker emphasized to her approaches that he felt might be helpful to the mother in her efforts to develop a more positive self-image in the child, explaining to her that it is a slow difficult process, and suggesting she make real efforts to compliment him but avoid trying to convince him forthwith that he is a good boy, but instead to approach it in a step-by-step basis commending him for his achievements rather than drawing from them the major conclusion that he is therefore a good boy. She seemed interested in some of these ideas. Worker felt she likely can use them with some success in her efforts to help this child. She accepted another appointment to discuss the situation with worker again June 19 at 10:00 A.M.

Norman F. McFarland, A.C.S.W.

EXHIBIT #9-B-1

6-19-69
Worker talked with Mrs. Satterfield, James Ramey's foster mother, and then with James. It seems there has been some improvement. The problem with James wetting the bed seems to have subsided considerably. They have also tried ignoring some of his objectionable behaviors and found that this has been helpful with some of the problems. However, many problems remain. Mrs. Satterfield seems to understand this and is willing to accept the fact that therapy with this child is going to be a long-term proposition.

She reports that he has been attending Vacation Bible School. This has evidently left him so high that he has had a difficult time getting to sleep and has been up until two or three o'clock every night. She also reports that she can tell no essential difference in his behavior when he takes the medication that the doctors prescribed and when he doesn't. He has manifested anger toward her a couple of times. Worker discussed this with her and suggested that she continue to even encourage him to express some of his anger toward her and toward others so long as he does not do it in extreme fashion. She is already aware that he has strongly tended to turn all his anger inward toward himself and his own things. Worker tried to help her see the need to develop the capacity to express anger in a controlled fashion toward other people and things than himself.

We also discussed at length his need for perfection. Worker gave suggestions to her to help him learn to tolerate such things as a bed with a few wrinkles in it and also suggested that she encourage him to be himself, as she was already beginning to do, by pointing out to him that he doesn't need to simply mimic the other children. She had noticed that at the table he watched one of the other children and ate exactly what they ate when they ate it. She also talked about his extreme neatness. Worker suggested she help him learn to enjoy children's play that involved him in getting dirty and that she encourage him to work with her in the yard and in the garden and such things as this where he would be able to get dirty and hopefully learn to do so without becoming frustrated.

She seems to have a very warm feeling for this child and is very interested in doing everything she can to be helpful to him. Worker felt she is also capable of using ideas and suggestions offered to her quite effectively.

Another appointment to see James and Mrs. Satterfield two weeks later was scheduled.

Norman F. McFarland, A.C.S.W.

7-2-69
Worker talked with James Ramey and then conferred with his foster mother, Mrs. Satterfield. Over-all it seems James continues to improve. The people who are working with him in Headstart this summer have noticed a great deal of improvement over his behavior in comparison with the previous year.

Mrs. Satterfield speaks of James having what she views as a dual personality. She goes on to describe him as extremely hostile at times and extremely tender and loving at times. She illustrated this by describing the different ways he reacted at the Family and Children Service agency and another agency where he had been taken for testing. The Family and Children Service agency found him almost unbearable, and at the other agency they found him quite cooperative and lovable. Worker suggested it is likely that with the Family and Children Service being involved in the many transfers that this child has gone through in his few years, he has come to view them in rather hostile fashion. It was pointed out that because he is extremely emotional, his reactions are more pronounced than would be in a more normal child. However, since these reactions of an extreme nature seem to be coming less often and with perhaps some small degree of lessened severity, worker suggested it is therefore hopeful that this is a problem that understanding and development will, in the main, reduce to more nearly normal proportions.

EXHIBIT #9-B-2

He continues to wet the bed at times and stay dry at times. Mrs. Satterfield feels that he is no longer using this as a method of getting even. She bases this primarily upon her observation that he tends now to wet the bed more often when he is actually sleeping better. He still continues to have difficulty sleeping and will often stay awake until after midnight.

He also continues mimicking the other children in the home, especially the little girl that he admires most. Jimmy is also beginning to express more anger. The foster mother says she has, insofar as she could, simply been ignoring his expressions of anger so long as they are not extreme. Worker supported and encouraged her in this. We also discussed ways to devise a step-by-step plan of helping him learn that he does not need to mimic others in order to be safe and accepted. We focused particularly on his eating habits. Worker suggested she might first begin by letting him mimic one of the other family members rather than the little girl that he has mimicked so consistently, and perhaps then go on to suggest that he take the first bite sometimes and that she will follow his example.

Mrs. Satterfield still had some negative feelings about Jimmy being kept out of regular school this past year. Worker tried to help her see that it likely was a wise decision in view of the problems that he is coping with. Worker suggested it would be much easier for him to learn to cope more successfully with his emotional problems if he can be in some position in his class other than one of being constantly at the bottom or behind. Worker suggested that since he is a year later starting, perhaps he will find it easier to achieve and that this will expedite his efforts to mature emotionally.

Someone had mentioned the possibility that we might want to consult with her and see James on a weekly basis. She felt this would be quite difficult in view of the distance involved. Worker also agreed, in view of her seeming competence and the continuing over-all direction toward improvement that James seems to be manifesting, that it would not be necessary at present to think in terms of weekly visits. After some discussion, we scheduled the next interview for July 31 at 10:00 A.M.

Norman F. McFarland, A.C.S.W.

7-31-69
Worker talked with James Ramey by himself, then talked with his foster mother, Mrs. Satterfield, while James waited outside. James is still rather reluctant to become involved with worker. He stated that he didn't want to talk although he would talk a bit when invited to discuss games he had played at Headstart and such things as this. He was also very interested in playing games with worker. He was curious about the paper holder. Worker allowed him to cut some paper with the paper holder. He seemed to enjoy this immensely and wanted to continue it. Worker explained he didn't have other games to play but would try to have some when he comes again.

In talking with Mrs. Satterfield, she feels that there is continuing progress. She says that the Headstart teacher has the same view of James. He is still some trouble but much less than previously. The mother also reports that he has loosened up enough to where he will finger paint and get himself pretty messed up in this fashion without being bothered about it. He also is less prone to mimic the girls who are also a part of the foster family. He is finally beginning to like the Headstart program.

He is also beginning to have tantrums when he cannot get his way. Worker discussed at great length with Mrs. Satterfield ways of coping with this behavior, essentially suggesting that she ignore it as far as is feasible and that she not insist on his stopping it immediately even when it becomes intolerable, but instead shift him to another room or even out in the yard, inviting him to continue until he is through and then return. Worker went on at some length to support her in the necessity of setting limits to help her feel free from any guilt in setting necessary realistic limits. Worker pointed out

EXHIBIT #9-B-3

to her how these are just as essential as his being given some freedom. She still maintains a very warm feeling for the child and seems to be gaining a real sense of achievement in this boy's seeming continuing progress.

Another appointment to see her about a week and a half after school starts was scheduled. He will be seen Thursday, September 4 at 10:00 A.M.

Norman F. McFarland, ACSW

9-11-69
Worker talked with James Ramey and his foster mother, Mrs. Satterfield in separate interviews. James didn't want to talk. He sat rather quietly making obvious efforts not to respond. However, when worker sought to engage him in some activities, he responded readily. He drew a picture of a man's face, wrote some figures on a sheet of paper, and put a puzzle together. He started off well but became a little anxious when he couldn't find the third piece to place readily. Eventually he was successful in putting the puzzle together in a quite reasonable period of time. We also played with a ball a considerable amount. He became quite excited about this and obviously enjoyed tremendously hitting the ball and he was especially thrilled when he hit the ball so fast that it hit worker. He also showed surprisingly good coordination in throwing the ball at the waste paper basket. He remembered the game we had previously played cutting paper with the latter opener and wanted to repeat this. He pushes limits and wants to continue playing whatever he is playing and test worker out to see if he will enforce any limits.

The explosive release of his feelings in these play situations suggests that this young boy is likely having a terribly difficult time coping with a lot of very deep feelings.

Later.
In talking with Mrs. Satterfield, she focused in the main on her worries about James being placed in a special education class. It seems that there may be some reality to some of her concern, since the class was just being organized. He was in with just two other pupils for a while and then other pupils were placed. She feels very strongly that this made a tremendous difference in James' attitude. Because of the depth of her own feeling, worker wondered, however, if she were not projecting a great deal of her own feelings about the special education situation onto Jimmy. Worker encouraged her to ventilate her own feelings about this at some length and assured her that several psychological tests were in basic agreement that this seemed like sound planning. Worker further pointed out to her on the basis of his own knowledge of the child and on the basis of her own reports that it seems certain that Jimmy has multiple serious emotional problems that would make it extremely difficult for him to function successfully in a regular classroom setting, even if he were normal or above normal. Worker emphasized to her Jimmy's extreme fears and his obvious need for being successful and suggested that a special education setup was much more likely to provide some of these very basic needs. Worker suggested that they were more fundamentally important at this point in Jimmy's life than the amount of reading or arithmetic skills he mastered. She seems perhaps a bit reconciled toward the end of the interview, but it is still obvious that she just has not really made her peace with this special education placement plan.

Another appointment to see James September 29 at 10:00 A.M. was scheduled.

Norman F. McFarland, ACSW

EXHIBIT #9-B-4

9-23-69
Worker talked with James Ramey and then later talked with Mrs. Satterfield, the foster mother. James seems a little more open and a bit more ready to relate to worker, although he still primarily wants to play. He again wanted to cut papers as we had in previous interviews but seemed a bit more angry and hostile in his cutting papers.

Worker had him write some for him. He started off by making a fairly good 4 and a 5, but when he attempted to make an eight, he got out of the lines, became frustrated, tried to erase it, then wanted to quit, and was pretty firm in his refusal to work anymore. He was also able to write his name fairly well except for the fact that he omitted the letter "i" and simply wrote "Jmmy". He still obviously enjoyed hitting the ball and seemed especially happy when worker held the ball so it became something of a punching bag.

Mrs. Satterfield is still worried about his being placed in special education. She reports that he seems to be regressing. He is mimicking other children a great deal. He seems to be withdrawing from involvement with other children. She reports that he has chosen as the one friend that he seems to really want to be with, the most severely handicapped child in the class whom she describes as having strong Mongoloid characteristics. She says that he is showing more anger and aggressive behavior toward the little girls who are also in the foster home.

He continues to have these difficult times at night that she describes as "night terrors" and he seems upset sometimes the day before and sometimes the day following recurrence of these. At times he simply refuses to cooperate. The teacher was quite frustrated by this at a time when they were having a fire drill. He said he didn't know where they were going and he wasn't going. She finally had to remove him physically to secure his cooperation in the fire drill.

Mrs. Satterfield seemed convinced that had he been left in a regular class where according to her reports he did quite well the three days he was there, that none of these problems would have occurred. Worker suggested that there were several reasons for thinking that he likely would have run into difficulties, perhaps even more in the standard classroom setting. Worker pointed out to her how difficult it was for him to stand failure and illustrated this by how he had refused to continue working when he made a mistake and got out of the lines. She could pick up on this and realize that it is extremely difficult for this child to tolerate anything out of order or any kind of failure. Worker pointed out he would inevitably have faced more of these kinds of things in the standard classroom setting and would have received less attention and understanding when he did fail to achieve than is true in a special ed situation. She seems somewhat reconciled to his being in special ed but is still angry at the school. She feels that one of the other children who is now in the second grade actually has less reading ability than Jimmy does.

Another appointment to see Jimmy Thursday, October 9 at 1:30 was scheduled.

Norman F. McFarland, ACSW

11-13-69
Worker talked with James Ramey, then talked with his foster mother, Mrs. Satterfield. James seems to be adjusting more readily to worker. He accepts limits without pushing quite as hard in testing to see if worker will enforce them. He still is obviously an angry little fellow and still tends to manipulate, but seems to be more nearly able to respond in a positive way to worker in the interview situation.

Mrs. Satterfield reports there have been some downturns. She feels this was caused in part by the fact that his teacher at school was out for a week and he had to have a substitute. This has been accompanied also by more bedwetting and he has on a couple of occasions tested her out in a more severe fashion than he had been accustomed to

EXHIBIT #9-B-5

doing. It seems, however, she set her limits and maintained them in a firm fashion. Worker upheld her in this.

She reports that he is achieving quite well in school. His teacher feels that he may be ready for the regular second grade level work next school year. He still, however, has some difficulties in school and reacts in rather extreme fashion at times. On one occasion a child attempted to choke him. He panicked and was unable to really work at his school work the whole day. He spent the entire day making black heavy marks on paper.

Mrs. Satterfield seems to have adjusted to his being in the special education class for this school year, and no longer seems to be seeking any change in this area.

Another appointment was scheduled for December 10 at 2:30 P.M.

Norman F. McFarland, ACSW

12-10-69
Worker saw James Ramey and then talked with the foster mother, Mrs. Satterfield alone. It seems that James has had a bit of recession. He was sick for a couple of weeks and seems to have regressed following this. On one occasion he bit his hand and there was still quite a scabbed over place indicating quite a sore. He also bit the buttons off his shirt. These behaviors had not occurred for some time. There were other behaviors indicating regression to more childish or primitive ways, but there seems to be some lessening of this trend as his physical health improves.

Mrs. Satterfield seemed somewhat reassured with worker's interpretation of his regression. He suggested that the interpretation can be checked out by observing whether or not the condition improves gradually as his over-all health returns to normal.

Another appointment to see them a month later was scheduled.

Norman F. McFarland, ACSW

1-29-70
James Ramey was in for his appointment. He seemed a bit quieter and more willing to sit and talk, although he was still obviously quite angry. He seems to have gradually become more accepting of worker. However, it seems there continues to be fluctuation in his over-all life adjustment. Mrs. Satterfield reported that he had been up until 3:00 A.M. the previous night. He had been having trouble with nightmares and what she terms "night terrors". He finally managed to get to sleep about three. This is the first time in several weeks that such an episode has occurred.

Mrs. Satterfield also relates that he has frequently expressed the wish that he were a baby recently. He has said he wishes he were a baby girl and especially her baby.

Another appointment to see James a month later was scheduled.

Norman F. McFarland, ACSW

EXHIBIT #9-B-6

3-4-70
Worker talked with James Ramey, then talked with the foster mother, Mrs. Satterfield. James seems essentially the same. He had become more over-active at school. The local physician had increased his medication. This seems to have helped some. However, the foster mother reports that when things seem to quiten down at school, he seems to have night terrors more frequently.

With a view to helping plan James' educational future and further efforts at therapy, psychological evaluation was scheduled for April 7 at 12:30.

Norman F. McFarland, ACSW

4-21-70
James was seen by Dr. Cole today. No notes were dictated.

4-21-70
Worker visited briefly with James Ramey while he was waiting to see Dr. Cole. He seemed angrier than usual and was quite hostile and aggressive. He threatened to overturn the ash tray in the floor and in general was more provocative than usual.

Later. Worker also talked with Mrs. Satterfield, the foster mother. She is apparently becoming discouraged with the prospect of being able to keep James. She reports that he is becoming much more destructive in his behavior. Instead of focusing it most of the time on himself and his own things, as he had in the past, he is beginning to be destructive toward other people and other people's property. She reports that he had quite thoroughly shattered over 100 of her mother's canning jars on one occasion. He also is attempting to destroy the other children's toys unless he has one just like it.

Since he is to be seen by Dr. Cole for at least another interview, no further appointments were scheduled by social worker.

Norman F. McFarland, ACSW

5-6-70
This is the second time I have seen James although no notes were dictated on our first meeting. As a matter of fact, the first meeting consisted mostly of talking with the foster mother. She described James' behavior as one of destructiveness, aggressiveness, and hostility toward girls. The first time I saw James he was rather reluctant to talk but did not engage in any aggressive or hostile behavior. As a matter of fact, he seemed quite calm and quite willing to go along with the examiner. However, he did display some passive-aggressive behavior, refusing to answer questions that it was fairly obvious that he knew the answer to.

Dr. Florene Young tested James in May of 1969 and obtained an IQ score of 69. She expressed the feeling that this was not his optimal performance and that he could possibly perform up to the dull-normal level.

Today I saw James for approximately 45 minutes and during this time he displayed some of the aggressiveness that his foster mother had talked about. For example, he was constantly fiddling with things on my desk and it was necessary to exert control on several occasions. He responded well as long as the examiner let him have his way, but as soon as he was told that he could not do anything, he pouted and responded with some aggressiveness. Although it is fairly obvious that James is an emotionally disturbed child, there is enough evidence to make one suspect some cerebral impairment. The foster mother claims that the pediatrician told her that he had some type of epilepsy but she has never seen him have a seizure. I am having Dr. Curtis examine Jimmy or the basis that it might be profitable to have him

prescribe some drugs that could possibly alleviate some of his symptoms.

It is fairly apparent that James has difficulty in controlling himself and has to depend on others to do the controlling for him. It is suggested to the mother that she respond to James in a fair but always firm manner. If given the opportunity to express anger without limits, James becomes quite upset and quite destructive. He should be told exactly what he can do and then these limits should be adhered to rather rigidly. Both James and his foster mother will return in two weeks.

Sharon Cole
Sharon Cole, Ph. D.

5-26-70
This young man is having an acting out problem. He basically acts out in an aggressive fashion and is sometimes almost uncontrollable in his behavior. However, he seems to have made considerable progress since staying in the present foster home. The present foster mother seems to take a very firm but loving approach with him, which I think is very desirable. The difficulty in school I think has been that the teacher which he has now is not able to deal with his acting out behavior in as realistic a manner as the one that he had previously. It is my recommendation that he be placed in a school where there is a relatively firm, reasonable disciplinary policy which is consistently applied. I would also feel that it would be of benefit to him if he could stay in the foster home for an additional year since he has been in seven different foster homes and I feel that this must be very upsetting to him and if he has to move, it would be even more upsetting to him. I do not feel that medication is indicated or would be of much value since as much medicine as would be required to tranquilize him would essentially knock him out.

John R. Curtis, M. D.
Psychiatric Consultant

EXHIBIT #10

A. Psychological Evaluation

B. Intelligence Re-Evaluation

C. Restaffing

PSYCHOLOGICAL EVALUATION

NAME:
CASE NO.: 17j617
AGE: 10 years, 11 months
BIRTHDATE: 8/14/62
COUNTY: Stephens

WARD: Children's ' South
ADMISSION DATE: 6/26/70
DATES OF EXAMINATION: 8/3/73, 8/9/73
DATE OF REPORT: 8/9/73

BACKGROUND INFORMATION: Jimmy is in the custody of the Stephens County Department of Family and Children Services, and has been hospitalized for the past three years in the Children's Building. Attempts to encourage this agency to actively seek a placement for Jimmy have been unsuccessful. He was last evaluated in December 1971, and the observations and conclusions in that report are considered valid at the present time, with the exceptions noted below. Jimmy has worked with a large number of therapists during his hospitalization, and reports of his treatment program and progress are contained in the ward chart.

TESTS ADMINISTERED: Wechsler Intelligence Scale for Children, Wide Range Achievement Test, Bender Visual-Motor Gestalt, Children's Apperception Test.

TEST RESULTS AND OBSERVATIONS: The results of Jimmy's performance on four IQ test administrations are given in the table below.

DATE	TEST	VERBAL IQ	PERFORMANCE IQ	FULL SCALE IQ
14 2/66	S-B			74
7/2/70	WISC	79	84	77
11/10/71	STANFORD BINET			66
12/15/71	WISC	65	64	61
8/3/73	WISC	71	67	66

S-B 11/68 IQ=69
7/28/68
FS=7

[illegible] previously, Jimmy's performance in IQ [illegible] of motivation, which was lacking during the 1971 administrations. However, during the present administration, Jimmy again seemed highly motivated. He persisted in his usual tendency to give up easily, but the performance shows little scatter, and there is no reason to believe that his potential to perform is any higher at this time. He is functioning within the Mild Retardation range of intelligence.

On the WRAT, Jimmy obtained the following grade level equivalents: reading, 1.8;

EXHIBIT #10-A-1

spelling, 2.3; arithmetic, 2.6. These results show a grade level increase ranging from .3 in reading to .9 in spelling, over the past one and a half academic years.

Jimmy's reproductions of the Bender designs showed a great increase in maturity and organization over prior testing, but the results were inconclusive in regard to identifying possible neurological deficits involved in perceptual-motor functioning.

Jimmy's responses to the CAT cards revealed the degree to which he has internalized the institutional routine. He verbalized no conflicts, and emphasized a routine of daily living which includes sleeping, getting up, eating, playing, eating, sleeping, etc. He showed a disinclination to project himself into situations which normally elicit dynamics related to a child's role in the family. He sees the mother as meeting the needs of the children, and the children as obeying the mother. Jimmy has apparently developed strong defenses against the hurt evolving from his deprivation of familial stability and emotional security.

SUMMARY AND RECOMMENDATIONS: Jimmy's behavior during the past two years has consistently been that of a mildly retarded child with very poor self-esteem and high level of frustration at his inability to compete effectively with his peers, or to meet his own unrealistic standards. However, during the past three months, Jimmy has undergone a large number of success experiences in the classroom and in his relationship with his therapist. His confidence in himself, although still limited, has increased, and he shows less tendency to be intropunitive and rejecting of himself. With the exception of a local family who has taken Jimmy for weekend visits [illegible] outside the hospital. It is felt that efforts to obtain a foster placement should be primary at this time, lest Jimmy become a permanently institutionalized child.

G. Robert Dixon
Senior Psychology Technician
Children and Adolescents Unit

Lee C. Groves, Ph.D.
Clinical Director, Psychology
Children and Adolescents Unit

/th

cc: Record Room, Ward Chart, File.

EXHIBIT #10-A-2

NAME: James Ramey
[illegible]
COUNTY: Laurens

REASON FOR TESTING: Re-evaluation of IQ for possible [illegible] treatment unit.

PHYSICAL DESCRIPTION AND BEHAVIORAL OBSERVATIONS: Jimmy is always neatly groomed & well-dressed. He is a well-developed, 12-year-old, freckle-faced, red-headed boy. His affect is flat; psychomotor activity is within normal limits though slightly exaggerated. His mood is fairly stable, but when he becomes frustrated it is volatile. He is oriented in time and place, and the nature of his interpersonal responses is best described as concrete and relating to the immediate environment (though some talk has been oriented toward forthcomirg school vacation periods). This ideation is that of a mildly retarded child; some perseveration is evident in his actions and speech. No evidence of psychosis or neurosis is evident, but he does show acute reactions to frustrative stimuli.

TESTS ADMINISTERED: Stanford Binet Intelligence Scale, Form L-M.

TEST RESULTS: Jimmy achieved an IQ of 60, which corresponds well with his previous score of 65. This score places him in the Mild Mental Retardation range and is felt to accurately estimate Jimmy's level of functioning.

He has a short attention span, lacks concentration, and seems to give up easily. He does show the ability to "think out" problems which do not require much attention, but even then, he still seems to require urging to complete the task.

SUMMARY AND RECOMMENDATIONS: James Lamar Ramey is a Mildly mentally retarded 12-year old boy. He has been in the Children's Building for four years though a more appropriate treatment program has been indicated for some time. His only behavior problem is his acute reaction to frustrative stimuli, however, this is not an uncommon characteristic of mildly retarded children.

James has achieved maximum benefit from the treatment program at Central Georgia Regional Hospital and it is strongly urged he be transferred to the appropriate developmental center, in his case, Georgia Retardation Center in Atlanta. The Stephens [illegible] contact with [illegible] other [illegible] or foster care [illegible] to the parents' need for limit-setting and [illegible] they (the parents) lay down initially. Jimmy can function appropriately if [illegible] but if rules can be bent, he will take advantage of the opportunity.

David Coron, Psychologist
Children and Adolescents Unit

Marilyn Edmiston, Ph.D.
Clinical Director, Psychology
Children and Adolescents Unit

/th

cc: Ward Chart, File.

EXHIBIT #10-B

RESTAFFING - 11-27-74 - Jimmy Raney

WARD PROBLEMS
1. Poor socialization with peers
2. low frustration level
3. bed wetting
4. teasing and provoking peers (improved some since admission)

COMMONLY SEEN BEHAVIOR
1. keeps himself clean and room neat
2. helpful on ward
3. temper tantrums
4. plays poorly with others (is improving)

TREATMENT METHODS
1. continued placement in school of special education
2. recreation and music therapy
3. placement in groups to increase socialization
4. program to reduce bed wetting
5. repeat EEG
6. Plan for foster care placement

GOALS AS INPATIENT
1. increased frustration tolerance
2. decreased bed wetting
3. increased socialization with peers

GOALS AS OUT PATIENT
1. Placement in foster home
2. adjustment to and continued attendance to community school of special education

EXHIBIT #10-C

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

MACON, GEORGIA 1:30 P.M. NOVEMBER 25, 1975

Deposition of Eli Charles Messinger, witness called by the Plaintiffs for the purpose of discovery and other legal purposes; taken by Lee Ellen McDaniel, Georgia Certified Reporter T-128, at 806 Georgia Power Building, Macon Georgia, beginning at the time stated above.

APPEARANCES:

For the Plaintiffs: GEORGIA LEGAL SERVICES
653 Second Street
Macon, Georgia 31204
Mr. David Goren, of counsel

Also appearing: Mr. Steve Granberg
Ms. Nancy Lindbloom

[2]

STIPULATION

For the Defendants: DEPARTMENT OF LAW
132 Judicial Building
Atlanta, Georgia 30334
Ms. Dorothy Y. Kirkley,
of counsel

Also appearing: Dr. Douglas Skelton

STIPULATION:

Deposition being called by the Plaintiffs for the purpose of discovery and other legal purposes. All formalities are waived. All objections except as to the form of the question

will be reserved until December 20, 1975, when they will be filed in writing to the Court. Witness and counsel agree to waive the right of the witness to read and sign the deposition.

ELI CHARLES MESSINGER

witness, first being duly sworn,
testified on

DIRECT EXAMINATION

BY MR. GOREN:

Q State your name and address.

A Eli Charles Messinger. 66 West 87th Street, New York, New York 10024.

Q What is your profession?

A I am a psychiatrist.

Q Are you certified to practice child psychiatry?

A I'm certified as a general psychiatrist and as a child psychiatrist.

Q What formal education have you had in this field—[3] what degrees have you earned?

A I earned a medical degree at Harvard Medical School; I had a year of medical internship at Grace New Haven Hospital in New Haven, Connecticut, which was associated with Yale Medical School. I had four years of psychiatric training at Bronx Municipal Hospital Center, Bronx, New York, which is associated with Albert Einstein College of Medicine—two of those four years of psychiatric training were in child psychiatry specifically.

Q Do you hold any academic titles?

A I am currentiy an Assistant Professor of Psychiatry at New York Medical College.

Q Could you describe for us your experience relative to child psychiatry?

A I've been in the private practice of child psychiatry part time since 1966 when I completed my training in child psychiatry. I've also been in the practice of general psychiatry. From 1966 to 1970, I worked half time at Montefiore Hospital, Bronx, New York, in the Department of Psychiatry. My main responsibility at that time was offering psychiatric consultation to the Department of Pediatrics at that hospital. From 1970 to September, 1974, I worked full time at Neighborhood Health Services Program—that's a federally funded comprehensive health care program in Manhattan, New York. I was a staff psychiatrist and later Director of the Mental Health Unit [4] there. I did community psychiatry, some administrative work, but mostly direct patient care of both children, adults and families. Currently, I am Director of the Child and Adolescent Psychiatric Clinic at Metropolitan Hospital, which is a large publically funded city hospital in Manhattan.

Q Have you written any articles or studies?

A I have.

Q What are they?

A I have written an article on the institutional treatment of the youthful offender—that was at a time when I was serving as Chief Medical Officer and Psychiatrist at a federal reformatory in Oklahoma. I have written more recently on drug treatment in children, specifically about Ritalin, which is a behavior modifying drug used in the treatment of certain childhood disorders.

Q Do you belong to any professional associations?

A I've been a member of the American Psychiatric Association since 1964. I'm on the Board of Directors of the New York Council of Child Psychiatry; I'm on the Board of Directors of Physicians Forum.

Q Can you describe your present position and duties and responsibilities you have in that position?

A I hold two titles—my clinical responsibilities are as Director of the Child and Adolescent Psychiatric Clinic at Metropolitan Hospital; my academic responsibilities are as [5] an Assistant Professor at New York Medical College. I am responsible for all the clinical services offered in a busy, fairly large psychiatric out-patient clinic serving children up to the age of eighteen. Part of that responsibility is the emergency services; that is, the evaluation for possible hospitalization of children, more often, teenagers, who are seen on a walk-in basis in our clinic, or in the emergency room of the general hospital of which we are a part. I am also a consultant to the Psychiatric In-Patient Service at Metropolitan Hospital which has fifteen, sixteen and seventeen year old children on its wards.

Q Do you have any particular familiarity with the admission of juveniles by their parents or guardians to public mental hospitals?

A Yes, in my current position I either evaluate directly or more often, supervise the work of child psychiatric trainees in the emergency evaluation of children and adolescents, and so I'm called upon typically several times a week to offer advice about the possible hospitalization of children to our facility or if there is no room at our facility to another public psychiatric facility.

Q Doctor, now I would like to ask you some questions concerning the role of parents in the admissions of children. What is your opinion in regards to the problems which lead parents to seek the hospitalization of their child in relation to [6] any difficulties the family itself may have?

A It's virtually impossible to evaluate the disturbance and needs of the child apart from understanding the disturbance and needs of the entire family. I think it's by now a truism in child psychiatry, a truism built over maybe fifty years of clinical experience in a wide variety of settings, that the pathology of children is inextricably related to the pathology of the family. Oftentimes, the disturbed or disturbing behavior shown by the child is best viewed as a communication or signal of distress to other members of the family, sometimes to people outside of the family.

Q Do you often find that parents as well as the child might need psychiatric help?

A That's true more often than not; it's usually clinically erroneous to focus one's attention exclusively on the child, rather than to consider the communication problems between member of the family, the adaptive or maladaptive balance that has been worked out between members of the family; and even when, in fact, the child shows evidence of significant psychopathology, it's important both in understanding the genesis of that psychopathology and formulating a rational treatment plan to work very closely with the parents. One of the reasons that I think that hospitalization should be used only as a last resort in the psychiatric care of children is that the extrusion of a child from the family to an institutional setting in many [7] ways precludes the possibility of work-

ing with the family. The two most common modalities of treatment used in working with the family is either parent counseling, which one works with father or mother or both to help them better understand the needs of their child or what's called Conjoint Family Treatment, in which one gathers together all members of the family and works to understand the communication gaps, distorted role allegations in the family; but, it is very rare that either of those kinds of treatment are practiced in a hospital setting, particularly when that hospital is some distance from the community where the family lives. Even when intentions are good, the fact that the child has been removed from the family often artificially quiets the situation down so there is a sigh of relief breathed by the parents and a troublesome child might indeed no longer be troublesome because no longer physically present. If, however, the child is returned to the family the same pathological interpersonal forces are at work, so the likelihood is that the same kind of pathology will be stirred up again.

Q Do you ever find in your experience that often the family may blame one particular member of the family for the problems that exist throughout the family?

A That's commonly known in psychiatry as "scapegoating" and it's a phenomenon that I have certainly seen. The mechanism here is that impulses or wishes or undersirable personal characteristics which the parent wish to defend themselves against are [8] projected onto typically a child chosen for a variety of reasons I mean, which child is chosen depends oftentimes on chance circumstances and then the child is treated as if indeed he was the vehicle of those undesirable characteristics. Sometimes this kind of role allocated works so well that the

child indeed begins to pick up such characteristics and it becomes a vicious kind of reverberating circuit.

Q In these kinds of situations, do you ever find that families can, in fact, mask their true feelings towards one another?

A Yes, indeed; I mean, families are pass masters at masking their true feelings towards one another—not as a deliberate, conscious attempt at deception, but really as a means of preserving some kind of sense of well being for themselves because they must live so intimately with one another. But this makes the task of the evaluating psychiatrist terribly difficult because unless the evaluating psychiatrist has had a chance to work with this family over an extended period of time the more subtle undercurrents of pathology might not be obvious. There's a term used in psychiatry to cover this kind of situation I believe coined by a psychiatrist particularly interested in family pathology—his name is Wynn—and it's called pseudomutuality.

Q In situations where, as you described, there may be scapegoating or there may be this pseudomutuality . . .

[9]

A Yes.

Q Is it possible that families . . . parents in relating facts to a psychiatrist will actually misperceive or misinterpret facts?

A That certainly happens . . . one doesn't expect family members to be entirely rational and objective in their perceptions of other members of the family. That's going to be even more true in a crisis situation, and it's usually a crisis situation that brings a family to request

admission for a youngster; still another factor which is particularly at work in families where there are adolescents is that there is a generation gap and the behavior of the adolescent is misunderstood or ill tolerated by the parent generation—that behavior is often seen by the parents as a sick or deviant behavior when in fact, it might be quite in keeping with the subcultural values and behavior patterns of the teenagers of that day, and there are many obvious examples that come to mind in terms of dress, hairstyle, dating patterns, etc.

Q In the parent's seeking of psychiatric assistance, is there a tendency for a parent to overemphasize any pathology that may exist in a child?

A Yes, because the parent is looking for a certain kind of response from the mental health professional that they qualify or the mental health facility that they call upon. If they have in mind for good reason or poor reason that their child needs to [10] be in the hospital, wittingly or unwittingly, they are likely to color their story so that that's the response of the professional who they speak to. Also in a crisis situation, they are more likely to focus on the behavioral characteristics of the child that they find unpalatable or which they consider sick and deviant. My own experience is that if one can work out this crisis situation short of hospitalization and there are a wide variety of means of helping a family over such a crisis situation, that in the weeks that follow one often gets a rather different picture of the patient, that is, some of his or her more healthy characteristics—friendships that hadn't been talked about, good schoolwork that hadn't been mentioned, a good relationship with some other member of the family, might surface which heretofore had not been mentioned.

Q In a non-emergency situation, that is, where, for instance, there is not an imminent threat of physical harm to anyone, is it necessary for the child to remain hospitalized or to be hospitalized to make those observations?

A No, in fact, I think it is terribly important for the child to remain in the family and his or her usual life situation in order to gather the kind of data that would enable one to make a really complete diagnostic formulation of the case. If one artificially removes the child from the family, one in a sense, subverts the data gathering process. One can then . . . one loses a great deal of potential information.

[11]

Q You mentioned that parents may have a tendency to color facts in particular ways—how does this misperception of facts or this incorrect reporting of facts affect a decision to hospitalize a child?

A I would say that the single most important source of data to a psychiatrist who is in the position of evaluating a child for hospitalization is the parent's account. Children and adolescents generally find it hard to speak to a psychiatrist. It usually requires several meetings to get a good sense of the child's personality and for them to develop the rapport with the psychiatrist that enables them to talk more freely about their lives, their families, their fears. Secondly, if the child is being brought against his or her will, to the psychiatrist, they are very likely to see the psychiatrist as an agent of the parents rather than as someone who is likely to be sympathetic to their point of view. Thirdly, children have difficulties in communications—the younger the child, the greater the difficulties in communicating about the facts of their lives. Psychiatrists

tend to believe other adults more than they believe the accounts of children and I have seen my colleagues suddenly ignore or discredit accounts by children when they differ from accounts by parents, even when it might later turn out that the child's account might be closer to the truth.

Q An accurate reporting of the facts is essential in making a decision to hospitalize?

[12]

A It is essential, because the only other source of data that one has is the direct observation of the child—that's also of great importance, but as I said, it's . . . you do not have a representative sample of behavior. One takes a twenty minute, one hour, two hour segment out of the child's life . . . a child's behavior is very responsive to the setting, so that being in a doctor's office, being in a hospital, being taken to a doctor against one's will is . . . will have a major impact on the child's behavior and how he communicates with the doctor; so that the single most important source of information is, in fact, outside sources. Of course the psychiatrist should if at all possible, combine both sources of information. I have found, though, that if there's a discrepancy between the reports of the parents when they say the behavior is terribly serious, a discrepancy between such reports and actual observation of the child, the psychiatrist will air in the tendency of believing the parents, and that was true in the case of one of the patients in question today—Joey, whose behavior in the office did not bear out the complaints brought against him by the adoptive mother and her second husband. They described him as rebellious against authority or unwilling to listen to authority; yet, if we take the psychiatrist as an authority figure, the psychiatrist described Joey as cooperative and Joey answered the questions addressed to him and Joey went with him to the interview room, even though it meant separating him from his adoptive mother, [13] and Joey went with him to the day room to meet other children when he was asked to do so by the psychiatrist. The parents in that case also described him as very hyperactive, but hyperactivity was not noted during the admission examination.

Q Do you have any experience in dealing with agencies like welfare agencies or as we have here in Georgia, Department of Family and Children Services, when they are guardians of children in the state and seek to admit them to public mental hospitals?

A I do, in particular, I have experience with the Children's Center, which is in the catchment area of the hospital where I work—it's the only shelter for children in New York City at this time; and about half of our emergency psychiatric evaluations are sent to us by Children's Center.

Q In your dealings with that agency and similar agencies, do you often find that they make inappropriate requests for the hospitalization of children?

A From a medical and psychiatric standpoint, they are inappropriate. From the point of view of the institution, I can understand it, because institutions have needs that are analogous to the needs of a family, so that similar kinds of dynamics might lead to the extrusion of a client from an institution that in other circumstances might lead to the family wishing to extrude a member . . . a child to an institution. For example, in the evening and nighttime shifts in most institutions, there are [14] usually fewer personnel. The needs of children for emotional sup-

port if anything, might be greater in the evening hours, because of the dark, less obvious activity to keep them busy, fears about bedtime, and so forth. Many of our requests for hospitalization come during the evening hours. It's not because children develop mental illness in the evening, but because the institution's capacities . . . abilities . . . to deal with the emotional needs of children are less if their staffing patterns are less. Similarly, if a psychiatric part time psychiatric consultant is available to the institution, we are less likely to get emergency referrals than if we happen to hit a day or an hour when that person is not available. But the general point holds true that the institution's needs and the needs of the individual who is referred for psychiatric evaluation for hospitalization are not always the same.

Q Do you ever find that an agency would decide to request admission to a public mental hospital because there is a lack of other alternatives in their community or in their particular area?

A Unfortunately, that often happens, so that one often sees gray cases—neither black nor white—in which the child does not suffer from significant mental illness, but is a behavioral problem or a learning problem or a difficult child for which agencies will not take responsibility, so as the most expeditious bureaucratic maneuver the child is hospitalized; [15] and I think that's the case with the two patients that are in question in this case. Neither of them show evidence of serious mental illness—I don't either of them should be in a hospital. In fact, I think it's detrimental that they are in a hospital; but my understanding is that they have suffered in one case a five year, in another case a six year stay in the hospital because public or voluntary social agencies such as foster

homes, group homes, residential treatment centers have not offered to take such children. In fact, I think this becomes something of a vicious cycle because the very fact of their hospitalization works against the possibility of such agencies accepting a child, because most agencies become very worried that . . . when they hear that a child has been in a state mental hospital.

Q Given these interests that you've described that parents may have or that state agencies may have in decisions to request admission to a mental hospital for their children or wards, do you think psychiatrists in mental hospitals can act as effective checks on inappropriate requests for admissions?

A No. I say no for two reasons—first, hospitalization is a most serious intervention in the life of any person and certainly in the life of a child. For that reason, I believe that the state has an interest in safeguarding a potential patient; that is, I think that a . . . there should be a review by a nonpsychiatric body . . . of such a grave matter as the hospitalization of a child. Secondly, I think that there are built-in institu-[16]tional and professional biases, which psychiatrists have, which make them . . . which make it necessary to have another view of the child's needs from an other than psychiatric viewpoint.

Q Do you think that psychiatrists have tendencies, for instance, to overdiagnose particular illnesses?

A Psychiatrists tend to overdiagnose. They tend to focus on pschopathology. They tend, as a group, and I'm not saying this is true of everyone, to focus more on the child's sickness than on his assets and strengths. They tend to err on the side of hospitalizing patients rather than taking the necessary effort to work out a treatment pro-

gram in the home and in the community. It's oftentimes easier for a hospital based psychiatrist to simply admit a child, rather than taking the time and energy to work out a treatment program that would enable the child to remain at home. There's also often considerable pressure from the family or the school to get rid of the child, too; not necessarily in a malicious way, sometimes parents are overwhelmed. I believe, as someone who has worked in a community clinic and had occasion in the course of four years there to hospitalize only one youngster, I believe that it is possible in the vast majority of cases to work out treatment programs that are effective short of hospitalization.

Q What interest would some psychiatrists have—what per—self interest would they have to decide to hospitalize somebody rather than to try alternative treatments?

[17]

A I don't think the self interests are narrow and selfish—I think that they are self interests in terms of professional identity. Psychiatrists, as medical people, are used to hospitals; they are used to thinking that hospitalization is a good thing, whether a medical illness or a psychiatric illness. They are used to thinking in categories of pschopathology. They are generally not trained to make the most effective use of community resources; that is a relatively recent trend in psychiatry, and psychiatrists who have been trained some decades ago, or who are trained . . . have been trained themselves in a state hospital setting, or who have had little or no experience in community psychiatry, will err, I believe, in the direction of overhospitalization of youngsters. There's also some more personal anxieties and concerns that psychiatrists

have that if they allow a child to return to the family and some mishap occurs, anxiety that they will be blamed, that their name will find its way into the newspaper, that they'll be chastised by their supervisor—psychiatrists are human beings, too.

Q Let me ask you some questions now, Doctor, about the nature of the science of psychiatry—do you consider that to be an exact science?

A Psychiatry is not an exact science. Our . . . the material, if I can call it that, with which we deal and study, is too complicated for it to be reduced to the hard and fast categories of the physical sciences. We are often in an area [18] of judgment and even value judgment. As a case . . . let me go further . . . we have very few laboratory measures as to the medic . . . as to the physician who works in medicine or surgery. The information that we gather comes from other people who have themselves problems in communication and their own personal interests. We spoke earlier about parents not deliberately, but unconsciously, wishing to present a certain view of the situation. In terms of direct observation and examination of patients, there are numerous studies in the literature and it's everyday experience of all psychiatrists that there are widely divergent observations and diagnoses made on the same patient. Some of these divergencies in opinion come about because there are various schools of thinking in psychiatry; there have been different historical trends in psychiatry so that a diagnosis which was more popular some years back might not be as much in evidence today. For example, in child psychiatry, there used to be an entity called functional behavior problems of children. That has almost entirely gone out of fashion and is now called minimal brain damage. Two cases in point are the

two youngsters we are concerned about today—both of them had more than one diagnosis given to them at the time of admission—it was the same child, the same hospital, yet, they were rather discrepant diagnostic labels given to these children. For Joey, it was hyper-kinetic disorder and adjustment reaction of childhood. These are two different kettles of fish—one is not the same as the other, [19] yet, either the same psychiatrist or two different examining psychiatrists and I don't remember which, offered these two labels. In terms of Joey, one diagnosis was borderline mental retardation and literally the next page in the document, at least the document which I examined, had the psychologist check off "Not mentally retarded".

Q Do you mean Joey or Jimmy?

A Sorry—Jimmy. The second child.

Q This inexactness of the science that you've been describing—how does this relate expressly in regard to children or adolescents?

A Psychiatric diagnosis is a problematic area—the American Psychiatric Association, which puts out diagnostic manuals is in the process of currently revising it. If the diagnostic manual has to be revised every several years, we are not dealing with hard and fast categories in nature. The American Psychiatric Association recently decided that homosexuality was not a psychopathological state, but rather something else. Homosexuals did not change, but psychiatric attitudes towards homosexuality changed. Now the situation is compounded in childhood and adolescent psychiatry; no one is satisfied with the diagnostic categories which are in the diagnostic manuals available to us today. In fact, at our hospital, we use two

diagnostic classifications—one the so-called DSM2 and the other put out by People for the Advancement of Psychiatry. The [20] terms are radically different. Now a third factor which further compounds the difficulties and should make us, I tnink, terribly cautious about psychiatric diagnosis, is that adolescence itself is a time of very rapid psychological change, of turbulence, of mood swings, of erratic behavior, of extreme behavior, so that the very essence of adolescence is dangerously close to what psychiatrists consider mental illness; that is, it is a matter of rather . . . it's a difficult matter of judgment to distinguish between a normal adolescent and someone whose psychopathology brings them beyond the range—and it's a range—of normal behavior. This is a widely appreciated fact in psychiatry. All authors who have written about diagnosis in adolescence caution that it's a very difficult matter to make diagnoses in adolescence.

Q What you're saying, in other words, is that one doctor may diagnose a particular child or adolescent as, in fact, showing evidence of mental illness, when another psychiatrist, perhaps coming from a different school of thought, or having different training, may look at that same person and induce that there is no evidence of mental illness, but that the child is experiencing "growing pains".

A That is possible. I'd like to add to that that one of the most crucial kinds of observations made in a psychiatric examination is a description and an assessment of what's called "affect"; that is, feeling state. It has been my experience [21] that psychiatrists differ very markedly in their assessment of feeling states. I've had the experience of being in a teaching conference in which a patient was interviewed before a group of twenty or

thirty psychiatrists and other mental health professionals and to hear a wide variety of opinion as to whether the patient was anxious, angry, depressed, frightened, etc. And these kind of assessments are of considerable importance in making a decision about psychiatric diagnosis.

Q Could you describe for us in terms of its effect and nature, the differences between institutional treatment of an individual—individual psychiatric problems—as opposed to out-patient treatment in a community setting?

A My opinion—and it is shared, I believe, by the vast majority of psychiatrists in practice in the United States today—is that out-patient care is to be preferred for the treatment of psychiatric disorders. As you probably know, in the last ten or fifteen years, there has been a broad movement towards community based facilities. The thinking—and I share it—is that the least social disruption that occurs in the life of the patient, the better. This is especially true of children, where social development is a crucial variable and where continuity in terms of academic program in school, peer relationships in school and in the neighborhood, and most critically, the continued relationship with parents or parenting figures is of vital importance. Hospitalization has within it [22] certain inherent disadvantages—they include removal of the child from its natural setting, family, neighborhood, school. There are in addition, many aspects of institutionalization which are detrimental to personality development. Generally speaking, institutions run in a regimented fashion; they deal with numbers of people, so that procedures, regulations, policies, routines, schedules have to accommodate the needs of the staff in managing large numbers of patients rather than the more specific individual needs of the . . . of any individual person. I believe

that no matter how forward looking and progressive the institution, there is inevitably some tendency to sacrifice the needs of the individual patient for the needs of institutional efficiency.

Q What effect could that have on individual growth and development?

A A child needs to have the opportunity to say "Here I stand, these are my needs, these are my wishes, I don't want to or I wish to" and while these are not always ignored in an institutional setting, there is a tendency for them to be ignored more often than in a family setting or even in a less structured small group setting outside the hospital. Institutionalization also decreases self-esteem; it often undercuts individual self-initiative. In my work with patients—both children and adults who have been hospitalized psychiatrically—even once and even for a brief period of time, this has left an indelible [23] mark on them. They look at themselves as a person who was put into a "nuthouse", "place for crazy people". It does have a crippling effect on their sense of self-worth. In addition, there are other kinds of social sequela of institutionalization that we are probably all familiar with; at least in New York State, if one has been psychiatrically hospitalized, you can't drive a taxi without getting psychiatric clearance. Employers might ask "Have you ever been in a mental hospital?". Other members of the family will know this about the ex-patient. In fact, I think "ex-patient" is a poor term to use because the social role of being a mental patient I don't think can ever be discarded.

Q Can we necessarily equate mental hospitalization with psychiatric treatment?

A The two do not necessarily go hand in hand. There are some hospitals which offer fairly vigorous psychiatric

treatment programs. Very often, however, well, in some instances hospitals offer no more than custodial care. That was my impression today in our visit to the Walker Building. In other hospitals what is known as Behavior Modification Programs and familiar treatment is offered. While I won't go into the advantages and disadvantages of those forms of treatment, they are not the same as individual psychotherapy or individual psychotherapy in parent counseling, which in my mind is the single most important modality of treatment for emotional disorders of [24] childhood. It's terribly expensive in terms of professional time and that's why it's relatively rarely offered in institutional settings.

Q If, we are talking not in terms of the two boys in this case who have been hospitalized for over five years, but if we talk about children who are inappropriately put in a hospital for a short period of time, say for instance, a couple of months, does that alleviate some of the problems that you described or are there still detrimental effects that inappropriate hospitalization even for a short period of time?

A The longer the stay in the hospital, the greater the likelihood of what's commonly called institutionalization; that is, acceptance of the kind of routine and regimented life of an institution. However, if a child is in a hospital even for what in our eyes is a brief period of time, those effects can nevertheless be quite damaging for two reasons. One is the child's perception of time is quite different from an adult's perception of time, and a day or a week or a month in the life of a child from a developmental point of view as well as from their subjective point of view is quite different from that duration of time for any of us as adults. Secondly, the stigma, both public

and subjective of being in a psychiatric hospital, will be present whether one is in for a day or for a year or five years.

Q As a result of your analysis of institutionalization [25] hospitalization and its effects, do you have any opinion as to whether there ought to be a prior hearing as to whether a child needs hospitalization in non-emergency cases?

A I believe that such a prior hearing is definitely needed.

Q Could you explain why and what issues you think ought to be addressed at such a hearing?

A There are several issues that should be addressed. First, there should be an attempt to gather all the pertinent data from as wide a variety of sources as possible about the patient, family and entire situation. This would of course include the interviews with the parents and interviews with the child. Other kinds of data about the family should be requested—sometimes the family has some embarrassing information about itself, let's say a charge of child abuse, that it would not willingly share with an examining psychiatrist, but which a court, for example, might have the authority to bring in. I believe that in all such cases there should be an examination by an independent psychiatrist of the patient and I think of the parents too. I say independent in the sense of it being a psychiatrist who does not work for the same institution of the same system as does the psychiatrist who is recommending institutionalization and someone who examines the patient at a different point in time, because situations change rapidly and dramatically in child psychiatry and the flurry of excitement and con-[26]cern and panic of one week might look very different when the child or family is

examined the next week. So, firstly, much more thorough going . . . data gathering and integration . . . special tests, for example—that might be done, like psychological tests, then would be possible in a one shot psychiatric interview for hospital admission. Secondly, the wishes of both the parents and of the child should be told to the court. I think the recommendations of all of the mental health professionals who have examined the people in question. There should be a vigorous attempt to find the least drastic form of treatment; that is, the form of treatment that is effective and comprehensive on the one hand, but which least disrupts the natural life of the child as possible.

Q Do you have recommendations for say, an advocate for the child, and what effect would this have on the child to be represented at such a hearing?

A I think it's of great importance that the child have an advocate because psychiatric opinion while it's valuable, is not the only way to look at a given situation; that is, there are built in biases in the way psychiatrists and mental health professionals view data, and to have someone stand as the advocate for the child in such a hearing, I think, is quite necessary. I believe that the child would see this as a protection of his rights and would feel better that he is being dealt with fairly rather than in some, what might to his eyes, be arbitrary [27] and summarily fashion. For example, in the case of the youngsters I saw this morning, Joey and Jimmy, I believe that that kind of judicial hearing at the time of admission would have prevented both admissions, and it's clear to me from the reading of the data and I admit that I was not there five or six years ago, but from the data that I examined and which was available to the people at that time, was recorded by

them at that time, their hospitalization could have and should have been avoided. And in fact, the court might have played a constructive role in opening up possibilities for foster home placement or other special non-institutional child care placements which were not, in fact, available to the people involved at that time.

Q What is your extent of familiarity with the specific facts of the two boys who are plaintiffs in this case?

A I have studied the documents about them for approximately thirty minutes apiece and spoke with each of them for thirty to forty minutes this morning.

Q In other words, based on your professional opinion, after speaking to them and perusing their records, you feel that there is a very serious question as to whether or not they needed to be admitted in the first place and in fact, it is your decision that they should not have been admitted?

A It's my opinion that they should not have been admitted—let me try to spell that out. With Joey, the two diagnoses offered were hyperkinetic disorder and adjustment reaction of [28] childhood. Those are diagnoses . . . those are some of the more benign diagnoses used in child psychiatry. Most often, hospitalization is requested for psychotic reactions of childhood, like childhood schizophrenia. In my clinic, there are literally hundreds of children with those diagnoses being carried in outpatient treatment. Those are the garden variety diagnoses in child psychiatry. Nothing in those diagnoses points in the direction of hospitalization; in fact, quite the contrary. Secondly, the degree of impairment noted by the admitting psychiatrist for Joey was moderate, not even severe; so that if we consider this in the behavior dis-

order category, it was not even a severe behavior disorder. With Jimmy, he was felt to be borderline retarded and I believe had a diagnosis of adjustment reaction of childhood. The degree of impairment noted at the time of admission was mild, so I am quite surprised that hospitalization was recommended by the evaluating psychiatrist.

Q Would a delay in admission to a mental hospital pending a hearing in non emergency cases be detrimental to a child?

A I would think that in almost all cases, it would be beneficial. As I said before, it is very hard to evaluate a situation accurately when it's a crisis situation, and that when the dust settles, one gets a much clearer and more thorough view of the situation. If a patient's behavior deteriorates so that their behavior truly becomes dangerous, then the parents could always return to the hospital to re-request admission.

Q As an emergency . . . ?

A As an emergency.

Q What effect do you think it would have on the child if he was ordered to have treatment as opposed to the present procedure whereby a physician checks on admission and makes the decision whether or not to admit him?

A If the child does not think that he should be hospitalized and is ordered to be hospitalized by the court, I assume that they will be unhappy about that decision. On the other hand, it at least does not make the hospital staff itself the culprit in the child's eyes to that decision, so that it might leave the hospital personnel more available to the child for the development of a therapeutic relationship. Also, I assume that most children would at lease see that they had their day in court and that the adults in his life acted in a judicious and deliberate and thoughtful manner about his future rather than hospitalizing him after a relatively brief examination and largely on the testimony of the parents.

Q Do you think it's therapeutically harmful to fail to place a child in an alternative setting to an institution when the child no longer requires institutional care?

A Yes.

Q Why is that?

A Because one wants to increase the child's adaptive capabilities. One wants the child to re-establish as soon as [30] possible ties to the family, friends, schools, other community groups, so that the longer one postpones this, the harder it makes it for the child to re-establish those ties. Childhood is a time of relatively rapid intellectual, social and emotional development. A delay is of greater importance in a rapidly developing personality than it would be in a relatively fully developed adult, who is more static in his psychological functioning.

Q Do you have any recommendations which could serve to prevent inappropriate continued hospitalization of children?

A I think there should be relatively frequent, periodic review by authorities other than those who are themselves responsible for the institutionalization of the child; of the continuing necessity of that institutionalization, and a vigorous attempt to find less drastic, more community based treatment possibilities.

Q Do you think a child would need an advocate in that kind of review?

A Yes, for two reasons—one as I said, I think the psychiatric viewpoint is not the only viewpoint which should be considered and secondly, one wants to have someone outside of the institution look into the situation because there's simply too much inertia in institutions and too much kind of self-servicing thinking. That's just true in all institutions, including the one that I work in and am a part of.

Q Specifically in relation to the two boys—Jimmy and Joey—what have you observed through your brief observation of their record and your interviews with them and the facilities in which they've been residing for the last several years as to their present state?

A My opinion is that both of these boys would be better served by less drastic measures than psychiatric hospitalization. My belief is that either a specialized foster home or perhaps a small group residence in the community could manage both of those youngsters. Their continued stay in a hospital setting is detrimental in terms of their emotional and social and intellectual development. I was especially concerned about the rather lifeless, passive self-effacing tendencies of Jimmy, who did not seem to be able to speak his mind or present his point of view and wishes in a forward and vigorous way. Joey is obviously clamoring for a home life and asks very explicitly to be taken care of in a family setting, as did Joey.

Q Jimmy?

A As did Jimmy—sorry.

Q Have you seen any other specific effects on the

children, for instance, those children, I believe, have been given drugs throughout their stay at the hospital. Through your observance of the children and your perusal of the records, do you think that that has had any effect on their development?

A I could only speak about that in general—I did not [32] look carefully at kinds and amounts of drugs. My understanding is that one child was on rather heavy doses of Ritalin—fifty milligrams per day—that's within acceptable range, but towards the upper boundary of acceptable range. And the other child was on Mellaril, which is a Phenothiazine drug. It's fair to say and I doubt that any psychiatrist would disagree, that there is increasing concern about the long term effects of medication, particularly when they are given over an extended period of time and particularly when they are given to children in adolescence because they are growing organisms. For example, Ritalin is a stimulant drug which at least in doses above twenty milligrams per day and one of our patients was getting in the neighborhood of fifty milligrams per day, has a growth retardation effect—a growth inhibiting effect—growth in terms of height and weight. It also causes a tachycardia; that is an increase in heart rate and in elevation of blood pressure. There are other dangerous side effects of Ritalin such as acute toxic psychotic reactions—those tend to be rare, and since they haven't happened, you know, with this child, they—it's not likely that we'll see it in the future. The point that I make is that one is always taking a calculated risk when one uses medication, and that there is increasing evidence that the stimulant drugs in children have long term consequences which were not anticipated. He also received Dextro Amphetamine, which is another kind of stimulant drug, which in all doses, [33] that is, there isn't a threshold

phenomenon—in all doses, has a growth retarding influence. Now with the Phenothiazine drugs, we've seen that, particularly for older patients who have been in state hospitals for many years, and those who are on heavier doses of these medications, that there can be rather serious crippling and irremediable effects. The syndrome that has received a lot of attention recently is called Tardivedyskinesia, which are involuntary, unsightly movements, which continue even when you discontinue the Phenothiazine medication.

Q Could you describe . . . you toured the facilities today at one of the state hospitals in Georgia, is that correct?

A At Central State Hospital.

Q About how long did that tour occur and what facilities did you see?

A It was approximately two hours, maybe an hour and a half, and I saw the children's unit, the adolescent's unit and the Walker Building. My summary of the tour was that I was favorably impressed by the children's unit, rather unhappy about the adolescent unit, at least its physical facility, and positively shocked that a seventeen year old person, no matter what her behavioral difficulties might be . . . was housed in the ward on the Walker Building which I saw.

Q Based on your professional opinion, could you describe what effect in terms of development of the children and adolescents, each of the wards that you saw, may have on the [34] individuals that are residing there?

A Obviously, the children's unit was built with many of the concerns which I have about hospitalization in mind, so that I would say that only the general growth

retarding effects of institutionalization; that is, some of the more subtle pressures toward conformity, toward rootenization, toward compliance, at least strike me in taking a look at the building. I did not get a detailed picture of the treatment program. In the adolescent unit, there was a kind of . . . it struck me as a mixture of . . . between barracks and a prison-like atmosphere. There was, in fact, wire netting, which apparently was installed at a time when senile patients were housed there. It was dormitory style sleeping arrangements. As we were leaving the facility, one youngster who was lying on the floor, and while that might happen, the staff is not responsible for the child lying on the floor, I was distressed that no one seemed on top of the situation to approach that patient and find out what the trouble was. Other youngsters admittedly a small number who had not been . . . who were not part of the group that was already at school . . . were sitting in front of the television set very apathetically and with no staff attention that I was aware of. Now I don't want to consider this a representative sample of staff behavior on that ward—I can only report what I saw. It was dismal, clean; the personnel seemed concerned and knowledgeable about, you know, their roles on the ward, but it truly was dreary. The [35] Walker Building was something else again. We did not see the seventeen year old young woman who was housed on that floor; she was off elsewhere, but we did see a number of women with the most overtly, bizarre, psychotic behavior, such that any lay person would know that he was in an insane asylum just as soon as the door opened up. And I don't understand why a seventeen year old person, no matter what their psychiatric problems might be, should be housed in such a center.

Q Did the psychologist in that ward describe to you

the behavioral problems of the seventeen year old?

A Yes, he did.

Q And . . .

A And they were in the nature of what sounded like rather serious behavior problems, but he said explicitly and I would feel it's internally . . . what he said was internally consistent . . . that she was not psychotic, that she was a severe management problem in terms of antisocial, obnoxious and sexual misbehavior.

Q What effect would buildings like the Walker Building and the adolescent's unit have on the development of the children and adolescents?

A I could only say for the Walker Building that it's disastrous. I don't know where to begin . . . I don't know how an adolescent, whether sick or well, could begin to cope in a constructive manner with living in close confinement with such [36] seriously disturbed and seriously regressed people. In terms of the adolescent building, I think that it's dreary and depressing and it seems to me to be countered to what should be the healthy aspects of adolescence.

Q And you said you were favorably impressed with the physical facilities of the children's building?

A I am.

Q Do physical facilities and a fairly active, responsive treatment staff alleviate the problems in the growth and development of the child when he does not need to be in a mental hospital?

A No.

Q Could you explain please?

A Yes. This is just a recapitulation of some of the things that I've said before—that to be in a mental hospital has a serious impact . . . serious influence . . . on one's own self-image. Joey and Jimmy will never forget these years. Secondly, they continue to be removed from any community involvement. I think we would all be in agreement that eventually they should be part of a community; that is, to go to a neighborhood school, albeit a special school, that they should live in a family, that they should belong to the Boy Scouts, or whatever else their fancy . . . wherever else their fancy lies, and that simply isn't being achieved in an institutional setting.

Q If your recommendations were implemented; that is, [37] either a prior hearing, a hearing prior to the commitment, in these boys' cases, or a periodic review to place them in an alternative environment after they've been committed, what effect would the implementation of those recommendations, do you think, would have had on the lives of these two boys?

A It would've been another story entirely. You're talking now about periodic review after institutionalization, and I want to remind you that I have very serious question about the initial decision to hospitalize these children, but if I pick up the story after they've been hospitalized, my belief is that with an outside, periodic review and a vigorous attempt with the authority of the court behind it to find alternative placement for such children, that it could have been found, should have been found and that much of the detrimental effect of the long-term hospitalization could have been prevented.

Q And it's your opinion that if they would have had a meaningful hearing prior to their commitment, they might

have never spent these last five or so years in a state hospital?

A Correct.

MR. GOREN: I have no more questions.

(BREAK IN QUESTIONING) (OFF THE RECORD DISCUSSION)

CROSS EXAMINATION

BY MS. KIRKLEY:

* * * * *

Q When a child is brought to you as a prospective patient, for out-patient treatment or in-patient treatment, do you view the child as a patient?

A Not necessarily, I view the child as the presumptive patient or the person whom the family views as the sick or deviant individual, but I feel it is my responsibility as a psychiatrist to look at the situation in depth to understand the interplaying forces between the child and the parents. More often than not, the situation is complex and there is an interplay between the needs, limitations and pathology of the child on the one hand and of the parents on the other hand.

Q Do you view it as your professional and ethical responsibility not to treat a child if he is not mentally ill?

A Could you restate that question?

Q Yes. Do you view it as your professional and ethical responsibility not to treat a child as a patient if you have diagnosed or evaluated him or her and decided that he is not mentally ill at all?

A I would yes with a certain qualification. If parents bring their child for psychiatric evaluation, there's some self-concern about that child—that can't be ignored; I

mean [41] to offhandedly say "Look, I think your child is normal, go home" I think would not really be offering the parents the kind of feedback they deserve.

Q For example, a parent brought a child in saying he needed a tonsillectomy—you would view it as your professional and ethical responsibility not to perform a tonsillectomy unless you thought he needed one, correct?

A Correct.

Q How does that differ in the practice of child psychiatry?

A It differs significantly in that the decision is a heck of a lot more complicated.

Q In what way?

A One is not viewing with tissue pathology that can be looked at, you know, with a speculum or under a microscope—one is looking at complex and delicate relationships between people.

Q But aren't there some psychiatric disorders that you can diagnose with more reliability than others, for example, organic brain syndrome?

A I would have to say that even the diagnosis of organic brain syndrome is not an easy matter. If a child . . . this is a technical point . . . if a child has a palsy that is a true muscle weakness or a difference in tendon reflexes, or a very obvious abnormality in the skull x-ray, or the electroencephalogram, one [42] might then, with some confidence, say that this is a child with organic brain syndrome. On the other hand, many of the evidences that are used by both neurologists and psychologists and psychiatrists for the diagnosis of organic brain syndrome are

behavorial rather than neurological kinds of evidence. So it's not always an open and shut matter.

Q But haven't recent studies over the past fifteen, twenty years, say, shown an improvement in the reliability of diagnoses at least for certain kinds of disorders, such as schizophrenia, organic brain syndrome?

A Definitely not.

Q You don't think that schizophrenia is now diagnosed with somewhat more reliability?

A No. I think it's as diffuse a concept as it ever was and the psychiatrists differ and disagree about it as much as they did fifteen years ago when I was in training. A personal experience that I have at the hospital where I work is that a few years ago, there was a psychiatrist researcher who was interested in manic depressive psychosis and the use of some of the newer drugs for manic depressive psychotics. They diagnosed manic depressive psychosis with a significant frequency on those wards. He then got a grant to go to another institution, same patient population going from the same catchment there, but without his particular interest in research investment in manic depressive psychosis—we have fewer manic depressive psychotics.

[43]

Q Are you familiar with Arthur Fallek's review of the classifications of schizophrenia?

A No.

Q You're not familiar with that at all?

A No.

Q And with his conclusions that it is diagnosed with about the same reliability as the need for a tonsillectomy?

A My friend, the need for tonsillectomy has undergone drastic revision as a child psychiatrist—it used to be done almost routinely in the 1940's—I was myself a victim of a tonsillectomy—it's rarely done now. Were these child patients that he was concerned about?

Q No.

A No. I could tell you that the very diagnosis of childhood schizophrenia is in question and William Goldfarb, who is probably the foremost researcher in the area of childhood—I don't know what to call it—schizophrenia or psychosis—recently changed his mind and after publishing a book called *Childhood Schizophrenia* now prefers to call the same behavior "childhood psychosis". And schizophrenia in childhood is a very different disorder than schizophrenia in adulthood.

Q You referred to behavior in families known as scapegoating?

A Yes.

Q How prevalent do you think this is?

[44]

A Well, I think it applies to one of the youngsters that we . . . I think it applies to Joey, who is one of the two clients we are concerned about. The story of Joey, and I think there is no one who is blameworthy, I don't think there is any villain in this piece . . . the story of Joey as I understand it, as I understand it from the record, is that essentially he had to be expelled from the family in order for his adoptive mother to successfully continue her second marriage; that the boy's behavior was such that it was intolerable for her second husband, and that there was a conflict within her as to which person she was going to relate to more intensively and she decided, I'm sure

after much soul searching, that Joey simply could not continue to live in the family. And I think he was, in a sense, sacrificed in order for that marriage to be preserved. It's rarely seen in that kind of clarity, but it happens in more subtle fashion frequently and I think we might even in our personal experience know marriages that seem to hold together as long as there's a child who is seen as sick, disturbed or deviant.

Q On what do you base the opinion that Joey was "scapegoated"?

A "Scapegoated" in a sense that he was sacrificed in order to preserve her second marriage; that it was necessary for him to be removed from the home in order for her to continue living with the man that she married.

[45]

Q I want to know where you got that from?

A From these documents, particularly from the report of the social worker who was working with the family prior to Joey's admission to the hospital and who felt that that admission was inappropriate.

Q You are not, are you, Doctor, referring to anything in these notes—you are referring to an affidavit?

A No, I am referring to something in these notes (examining notes). Oh no, I am sorry—I am referring to an affidavit from a woman social worker.

Q Do you know when the affidavit was signed?

A If it's not here, it's in the car. No, offhand, no. I would be happy to look for similar data here (examining papers).

(OFF THE RECORD)

A Let me read from the affidavit of Janet Scott, which is dated the eighteenth of November, 1975.

Q Well, that's already in the record; I just wanted to clarify that that was what you were basing your opinion on rather than the admission papers you have before you.

A If you give me a minute, I would like to look at those because I think that the information was consistent.

Q Sure.

(Dr. Messinger examines papers)

A Yes, I am reading from the summary progress note June, 1975—Ray Joey Master Lister.

[46]

> "This is shortly after admission the family tried to cooperate with family therapy. Mr. Sherma, even though apparently motivated at first, became discouraged with Joey's cyclic behavior and no consistent improvement. Mrs. Sherma was threatened by the process of really changing the situation. She felt a lot of guilt about Joey's condition. She really cared for Joey and it was a painful, traumatic decision to give him up. It is to her credit that she dealt with her feelings of helplessness and hopelessness Joey created for her in the hope he could be put in a successful foster home. Her own marriage was threatened by Joey's disruptive behavior in the home and this was the only course for her own natural child's welfare."

Q Do you know what happened when Joey went home on leave and visited Mr. and Mrs. Sherma with the new baby in the household?

A I know that it did not work out; the intimate details of that I don't know.

Q Are you familiar with Georgia's mental health program in 1970?

A No.

Q Are you familiar with the availability of foster homes or group homes in 1970?

A No.

Q Other than your reference to Joey's case as one of [47] possible scapegoating, could you say how prevalent scapegoating is in regards to admissions of children to Georgia's mental health hospitals?

A With reference to Georgia's mental health . . . ?

Q Yes—the seven regional hospitals.

A Hospitals . . . no, of course I can't.

Q Do you have a percentage figure for your own hospital?

A I'm not pretending that these mechanisms are so obvious that they're easily countable. I can say that in . . . and neither have I done a particular study of this mechanism . . . I could say that in a goodly percentage of cases, it is to the advantage of the parents, and not necessarily in a selfish point of view, it is to the advantage of the parent to extrude a child from the family that hospitalization is a particularly desirable way to extrude a child from the family in some senses, because it can be seen by the parent as well as by the professionals who are hospitalizing the child as a therapeutic manuever.

Q But it is in many cases precisely a therapeutic manuever, is it not? It is therapeutic for some children to be placed in hospitals?

A It is therapeutic for some children to be placed in hospitals, but the question is how to distinguish the sheep from the goats and what kind of procedural safeguards

should be built into the system in making those kinds of distinctions and whether [48] other treatment approaches might better address the family and community roots of some of the psychiatric disturbances that we are concerned about.

Q Do you think that you are able to tell the sheep from the goats?

A After considerable study of a child and family, information from school, other treatment agencies, I can offer, I think, a reasonable recommendation to parents and children about whether hospitalization is needed.

Q Do you think your process of evaluation and recommendation would be improved by requiring that the parents file a petition with the Juvenile Court?

A Yes, it would.

Q In what way?

A Because I look at these matters almost exclusively from a psychiatric perspective—there might be information that parents would be unwilling to share with me, but which the court might be privy to—I would be happy to have any additional information provided by other sources and I would be delighted to have an effort made to find placement or treatment modalities which I might not be aware of or which I might not have the key to unlock.

Q In Georgia, a parent could file a petition in Juvenile Court alleging that his child is mentally ill—is it the same in New York?

[49]

A A patient can . . . I'm sorry . . . A parent can file what's known as a Pens Petition that the child is a person in need of supervision.

Q But that relates to unruly or ungovernable conduct?

That's correct.

Q But not mental illness as defined usually in the health codes?

A They tend to overlap, but I understand your distinction.

Q So you know of no specific process whereby a child can be declared simply mentally ill by the court as opposed to a person in need of supervision in New York?

A Correct.

Q If there was such a judicial procedure available, then would it not be possible in cases where you have professional doubt for you to ask the parents to file such a petition rather than requiring that a petition be filed on every case?

A Please restate the question.

Q I presume from what you are saying about the values of the judicial procedure, one of the values would be the subpoena power to gain additional information; another value, according to your statement, would be the value of the court having other resources in which to place the child?

A Yes.

Q Couldn't you look at that procedure as an option; [50] you are not saying that in every case your professional judgment needs to be circumscribed by judicial procedures, but that in some cases, judicial process might be helpful?

A I believe that hospitalization is such a drastic and possibly damaging experience for a child that in all cases

except for obvious emergencies, that it is . . . that it should be mandatory . . . that the matter be previewed by a judicial body.

Q Even if you were positive professionally that you were making a correct recommendation and had no questions about the validity of your case history?

A Correct—I'm not infallible.

Q What would you describe as an emergency situation?

A An emergency would be a situation in which there has been behavior or there is imminent danger; tangible, demonstrable evidence of imminent danger to self or others.

Q You did say though, that even in non-emergency situations, the family viewed it as a crisis, is that correct?

A Often.

Q Most of the time or often?

A Most families ask for hospitalization of their child when there is a crisis in the family or at least when they view behavior as being a crisis, yes.

Q Don't most of them view hospitalization as a last resort for the child?

A Not necessarily . . . parents are not as knowledgeable as [51] perhaps we are in this room about the range of treatments available . . . that's particularly true of less well educated parents. Sometimes, as in my community, the hospital is virtually the only health facility around. They don't have the money to go to a private psychiatrist.

Q But isn't it the role of the admissions unit staff to advise the parents on what other options are available?

A It should be, but as institutions . . . it should be; however, first, there aren't, at least in the particular catchment area I work, very many other options available. Secondly, if one is working in a facility on an emergency service and there are empty beds on that efficient service, there's a tremendous tendency, tremendous human tendency, to hospitalize that child if in doubt.

Q Why is that?

A Because one becomes . . . I don't know what the word is . . . habitualized, socialized to using that means to resolve the difficulties at hand, and because it might be more time-consuming and difficult to try to work out things with a school, for example. Oftentimes, these crises arise in the school setting. Because psychiatrists rarely get up and move out of their office or out of their hospital to visit a classroom or speak to a school principal, and because many psychiatrists are either not trained to or not as comfortable in operating in a community psychiatry framework as opposed to a . . . hospital framework.

[52]

Q This judgment is based primarily on your experience in New York in Metropolitan Hospital?

A It's based primarily on my experience in New York, not necessarily at Metropolitan Hospital, but from my speaking with colleagues, observing the behavior of other professionals, and reading of the literature.

Q Is that phenomenon, that is, admitting to an empty bed, any different in a private hospital and a public hospital?

A I can't answer that question for sure because I haven't worked in a private hospital myself. I think the pressures there might be different and financial considera-

tions might become paramount . . . not paramount, but contributory to the decision.

Q That the profit . . .

A The profit motive might enter into . . .

Q Might enter into the decision.

A Yes. In a public hospital, there are also considerations about census; that is, if the census of a facility falls too low, it's likely to be closed, or a person known to be transferred, and there's sometimes an effort by the people in charge of that unit to maintain it simply because that's their territory for work and that's their job line at stake.

Q Are you familiar with the techniques we are using in Georgia to avoid that?

A No, I'd be happy if you have some. I'm sure it's [53] a problem you have wrestled with.

Q Are you familiar with Daniel Offer's work "The Psychological World of the Teenager"?

A No, I'm not.

Q You're not familiar with the article at all?

A No.

Q Then you're not familiar with his conclusion that you can distinguish between normality and psychopathology in adolescents?

A I'm not saying that one can't make judgments about normalities, psychopathology in adolescents; I'm called upon to do that every day of the week. I want to introduce a note of skepticism about the exactitude of that decision, and more importantly I'm concerned about the process by which that decision making is made; that is, I'm con-

cerned about when, where, by whom and with kinds of safeguards that decision is made. And I feel that it's too . . . that the deci . . . you know, decisions about psychopathology if you want to put a child into out-patient group treatment versus out-patient individual psychotherapy, we don't want any judicial hearing about that, but when you take the radical step of removing a child from the family and institutionalizing them in a psychiatric facility, I then do want that decision reviewed by an independent body. And I want it to be reviewed before it happens rather than after. And I would hope that the judge would listen very [54] carefully to the evaluating psychiatrist or psychiatrists; and that information should be respected.

Q Are you familiar with court commitments in New York? Have you treated children who have been committed by the courts?

A I have very little first hand experience with court commitments.

Q So you wouldn't have any opinion about whether or not, in your judgment as a psychiatrist, courts are committing inappropriately?

A My understanding is sometimes those hearings are anything but exhaustive reviews of the situation, so I am not talking about a superficial, rather state kind of judicial review; I'm talking about a serious investigation of the situation and collaboration of professionals with counselors, etc.

Q I had started out asking a series of questions asking about diagnosis in adolescents, and I think one portion of your testimony was that it was particulary difficult to diagnose an adolescent?

A Correct.

Q Would you state again the basis of that opinion?

A First of all, it's a widely held opinion. Adolescence is a time of turmoil, of anxiety, of depression, of mood swings, of extreme behavior fluctuation. Now these aspects of behavior often enter into a diagnosis of psychopathology in an adult. If there are rapid mood swings in a thirty-five year [55] old person, we use that as evidence of psychopathology. We couldn't do that . . . we shouldn't necessarily do that with a youngster of fifteen. Also, the diagnostic categories in adolescence are much less well defined and there's even less general acceptance of which categories under who falls than in adult psychopathology. Whatever problems there might be in the classification of adult psychopathology, they are much greater in adolescents and children. That's a fact.

Q What studies or other psychiatrists do you rely on in particular—you say it is widely known?

A I would say that's something that I have heard from my teachers and supervisors, from my colleagues, that I have read in the literature.

Q Nothing specific you could mention four or five articles or four or five books?

A I will cite you some material from the literature. As I said earlier, this manual relates to the diagnostic and physical manual abilities of the American Psychiatric Association is one way of approaching psychopathology in adolescents. An expert group, an expert committe of the Group for the Advancement of Psychiatry, which enjoys an excellent reputation in American psychiatry, sat down and came up with a radically different set of classifications of childhood and adolescent disorders. It seems to

me that the tremendous variance between these two groups speaks a fundamen-[56]tal lack of unanimity. Let me think for a moment. I have been reading the literature recently about the diagnosis of such because I have to speak at a Grand Round Presentation in December; I have failed to come up with any good articles on the subject, and I think that speaks of the difficulties, the imminent difficulties in this area rather than any shortcomings in the psychiatrists in this area.

Q What do you view as—I know this is a very general question—as the parents' responsibility in raising a normal child?

A Could you try to be more specific?

Q In the popular literature now, it is the general trend to think that parents ought to take the lead in prescribing, scheduling doctor's appointments, necessary care and training—that parents need to set the requirements—this is what is needed to develop a good basis for the child to grow up comfortable in his own mind. I'm just asking you if you agree with that issue?

A I would say that that is a question of value and that if I responded to that question, it would be more as a father than as a child psychiatrist. There is a legitimate difference of opinions; I think too much depends on issues involved. I won't have a discussion with a child about an appendicitis. I would and I do have discussions with my children about which after-school activities they are interest-[57]ed in. It also depends very much on the child's individual personality.

Q But you wouldn't have a discussion with them about necessary shots, regular doctor visits, regardless of how the child felt about these things, regardless of the child's wishes?

A Not when it concerned straight medical care.

Q As I understand your testimony in regard to psychiatric hospitalization, you're not saying that the child should not be compelled against his will to go into a hospital, but that the hospitalization should be a last resort and should be based on judicial process?

A Correct.

Q Is it your opinion that the standards for involuntarily hospitalizing a child should be the same as involuntary hospitalization of an adult?

A You would first have to tell me what they are.

Q In Georgia for an adult, he has to be mentally ill and either dangerous to himself or others or incapable of taking care of himself.

A Well, the last part—that couldn't apply to a child, because a child is relatively dependent, but otherwise, I would agree that the same standards should hold . . . that is of danger and mental illness.

Q But not only of danger—in other words, Georgia [58] has a stipulation for involuntary hospitalization for a person who is mentally ill and in need of treatment.

A I agree with Georgia's position.

Q For a child of five, wouldn't you say that he should be mentally ill and in need of treatment in a hospital as a last resort, but not required above and beyond that that he be dangerous to himself or others?

A Could you rephrase that?

Q Then you are advocating that a child be hospitalized if he is mentally ill and in need of treatment, is that correct?

A This, I see, is a somewhat separate issue from before. I would say that the forced hospitalization of a child and I think it's especially true in adolescents, should be only in cases where there is mental illness and dangerousness.

Q What about adolescents?

A In the case of an adolescent and a child.

Q In a child no matter what his age?

A The answer would have to be affirmative.

Q Do you think that it's important that mental illness be treated early?

A Yes.

Q Why?

A I believe that, particularly for children, since [59] they are developing organisms, one wants to maximize their possibilities of adaptive behavior.

Q Do you believe that they should be treated even when they are not dangerous to themselves or others?

A That's a sticky matter in child psychiatry because relatively few children seek psychiatric help on their own—they are nearly always brought by the parents—and it is one of the dilemnas facing the child psychiatrist because he then has to enlist the alliance of the child; but quite honestly, if an adolescent is brought to me with a condition other than one which makes for dangerousness to himself or others, and he is dead set against treatment, I try to respect their wishes and to leave the door open for further contact in the future and I have found that the adolescent respects the fact that I respect their wishes, and at least on occasion, I have some come back at a future time.

Q Let's take children and then adolescents, by which I mean up to thirteen for the child. Do you think that a twelve year old has a capacity to make an informed judgment about whether or not he should be treated?

A Treated in what way?

Q Treated—that he is mentally ill and that he then has the informed capacity to decide whether or not to be treated by a psychiatrist, either as an out-patient or in a hospital.

[60]

A If we are dealing with a twelve year old, then I think we are dealing with a very . . . that's the gray area in my own thinking, so if you don't mind, let's take either an eight or a fifteen year old—that might at least clarify in issues. It depends on the terms in which it's put, and that's the whole business of child psychiatry—how to communicate with a child in terms that are meaningful to him . . . terms of his vocabulary, cognitive understanding and emotional understanding of the situation; and I think that it is possible to talk with children as young as eight in a way that really keys in to their perceptions and feelings about the situation in which they live, so that treatment can be presented to them in a way that's meaningful to them and which they might see as beneficial.

Q Now suppose an eight year old said "I'm not going to Dr. Messinger's office at all"?

A I would certainly want to discuss that with the child himself to understand where he's coming from. I would certainly want to discuss the situation further with the parents and well, actually . . . it has actually never come down to that in my own practice. I think it would depend on the seriousness of the problem at hand and if I

felt that the problem was quite serious, I would insist—I would say to the parents that they should use their authority to bring the child in and I would explain to the child that whether he liked it or not, we as adults saw this as a grave situation and that perhaps he didn't [61] understand it now, but we assumed that he would eventually understand our action.

Q Okay—now let's take a fifteen year old.

A With the fifteen year old, my tendency would be to give them discretion short of emergency kinds of behavior; that is directly self-injurious or homicidal behavior.

Q Starting at fifteen or is that just where you are sure of your opinion?

A I'm afraid that since we are dealing with the developing child and children who develop at different rates that, much as I understand your interest in coming up with a specific chronological age, I cannot do it. My overall tendency would be to enlist the patient as an ally in the exploration of his problems and whenever possible, to grant him or her the respect of deciding whether or not they are in need of counseling or treatment.

Q With the fifteen year old, should the parents use their authority to at least get him into the office?

A I have no objections to this. Parents have a right to make their wishes known too.

Q But with a fifteen year old, I guess we'll just take an average fifteen year old in intelligence, you are saying that the particular problem in diagnosing is there, because of the turbulence in adolescence and rebelliousness of adolescents?

[62]

A Yes.

Q Don't those factors mitigate against a fifteen year old being able to make an informed judgment?

A In some ways, yes; in some ways I think adolescents are particularly perceptive about themselves and adults often have a hard time understanding and empathizing with adolescents, including the psychiatrist.

Q Would you use this standard on an individual basis as to whether or not a particular adolescent should be able to reject treatment, rather than drawing a chronological age at which one should be able to reject?

A I'm able to . . . I mean I'm not, you know, in the legal profession, so I'm not able to use that kind of . . . I have that kind of latitude, yes.

Q For any patient up to eighteen, you use latitude in deciding which one can make an informed judgment about treatment, and which one cannot?

A Again, are we talking now about out-patient treatment or in-patient treatment, because I make a firm distinction between those two.

Q Okay, let's take out-patient treatment.

A In fact, I think that patients, whether kids or adolescents, but certainly by eleven or twelve years of age, children vote with their feet—that is, a twelve year old who doesn't want to come in to see the psychiatrist ain't [63] coming, you know, he stays at school, he can't be found, he doesn't talk—I've lived through many sessions in which twelve year olds don't say a word—they make their will known. So we can say, you know, here in this room, that they should be forced, parents should use

their authority to have the child engage in treatment, but one can't, in fact, force the issue.

Q We were going back to adolescents, and you were saying that you saw a distinction between whether or not a child or an adolescent should be forced to have out-patient treatment or forced to have hospitalization.

A I would not want to force any adolescent to have out-patient treatment.

Q From thirteen to eighteen?

A Correct.

Q And what about hospitalization?

A I think the judicial safeguards that we've been talking about should be operative.

Q Using a standard of dangerous?

A That happens to be my personal opinion, but I could see others arguing that mental illness and a need for hospitalization should be the standard and I wouldn't, you know, I wouldn't move out that as another option.

Q You've expressed a preference for psychotherapy by a psychiatrist?

[64]

A For those children who are sick enough to be in a hospital, I think they also deserve direct treatment by a psychiatrist, preferably a child trained psychiatrist.

Q But doesn't a team approach by a unit in the hospital give more pervasive treatment at all hours of the day?

A I like the team approach; I don't think that these two are incompatible, but I think that hospitalization

should be reserved for the sickest kids and I think the sickest kids deserve treatment by the mental health professionals who are trained to deal with the sickest kids and those are psychiatrists.

Q You've talked about the effects on a person's self image from hospitalization?

A Correct.

Q Are you familiar with this article by Goven Fain—"The Stigma of Mental Hospitalization"?

A No.

Q Are you familiar with this article by John Cumming and Elaine Cumming on the stigma of mental illness?

A No.

Q On what do you base your opinions?

A Largely on clinical experience.

Q Your personal clinical experience?

A Correct . . . some of my testimony about the injurious effects of institutionalization I think can be corroborated by [65] the experiences of Joey and Jimmy. One of the things that I noticed about Joey is that he was—he latched onto whoever seemed to offer him what I would call a feeding experience, a nurturing experience, giving experience, at that moment. Now I can't make an ironclad case that's the result of his institutionalization, but I'm sure that it is; that is, in an institutional setting because one doesn't have the mother and father to whom one can rely on for nurturance over an extended, really indefinite period of time, one has to make use of whoever is available at the moment. Also, one learns that the good guy or the good woman who might be available today

might not be available on the next shift or might not be available the next week or month, so one takes what one can when one can. I saw a great deal of that mentality in Joey. What I saw with Jimmy was, I think, an apathy and listlessness that's another kind of adaptation to institutional life; that is, one gives up—one gives up asking, because one's needs have not been met on so many occasions. I think that's in fact more serious in its consequences than Joey's gobbling up whatever comes his way and making known in no uncertain terms that he wants more more more.

Q But isn't what you're saying, really, that these two twelve year old boys need a set of loving parents who can cope with their behavior?

A Yes, but they don't; so the question becomes what [66] can we, as the adult community, offer them in lieu of that? And it seems to me that a foster care setting would much more nearly approximate the kind of continuous, reliable parental care than would even the best of institutional centers.

Q Let's go, though, beyond that, another aspect was the question of stigma, not what happened to them in the hospital, but how they felt about it and how other people felt about it after they got out? I think I could fairly summarize the study of Goven Fain on a follow-up of patients from a mental health hospital—that the patients felt like their life had improved after hospitalization and that in significant areas—work, home life, relationships with others—they saw an improvement in themselves—do you disagree?

A Certainly there are patients who, in fact, do improve in hospitals and I recommend hospitalization to

some patients. I would ask, though, whether these were patients who were hospitalized as children, whether they spent five or ten years in hospitals, and whether they themselves sought out the hospitalization or were put in by other people who "volunteered" them . . . I think those are important variables.

Q Isn't the type of hospital also important—whether or not they've had significant relationships with their home community while they were in the hospital, whether they've been out on convalescent leave?

A To some extent, it is.

[67]

Q So there are really many variables in how hospitalization can affect a person?

A To a degree, there are many variables. I can add that these two youngsters are very desirous to leave the hospital.

Q Let's turn now to the procedures which you've been proposing.

A Yes.

Q From your discussion of the problems of diagnosis in inter-related pathologies of the parent and child, I take it that you view the dynamics of the situation when a family presents a child as a problem to you as being a very delicate one, that there are some delicate human relationships that are involved, that you, as a psychiatrist, try to understand what's going on behind the facade that people present to you?

A Yes, and not to pre-judge who is the patient; that is, not to take at face value the judgment made by the

parents that the child is the one with the problem—it might, in fact be true, more often than not, it is more complicated.

Q What kinds of questions do you ask to find that out or what do you do?

A It takes a few years training to learn that—I don't mean to treat your question lightly—what do I do. I try to establish a tone that allows for people to speak forthrightly about each other and about themselves. I try to give [68] them time in which to do that. I try to establish a spirit that no one is at fault. I try to give people the benefit of the doubt and to credit them for the positive that they bring to the situation. I try to understand the way that they could see the situation. I try to offer suggestions that might be usable and might be acceptable to them within their own cultural framework, their own degree of sophistication; and I guess, in general, I try to establish a climate in which, as a group of people in trouble, they can take a look at what's going on and take positive steps to correct them.

Q How many Pens hearings have you attended in New York?

A I can't in all honesty say that I've attended; I might have one or two . . . I don't . . . they just don't come to mind.

Q How about delinquency proceedings?

A In New York, let's see . . . then the answer is no—none.

Q Any commitment proceedings for children that you have attended?

A Commitment proceedings for children I don't think I have—for adults a handful.

Q Well, that's not the best basis for this question, but let's proceed on that basis, then. Do you think that the proceedings you have observed in any way simulate the process which you feel is necessary to discover what's going on in a [69] family group?

A Well, I'm really not in a position to answer that because the adult commitment proceedings, the family as the locus of concern was . . . the family was not the locus of concern, but the offering of data as objective as possible to a judicial third party . . . that I thought was worthwhile; that is, that one had to establish in a factual way and use nontechnical terms what was going on. Psychiatrists tend to use catch words that are meaningful to them, but which might or might not be well-established in fact.

Q But the process that you've described is patient sensitive individualized for that particular group—it would not be a matter of, you know, a 10:00 A.M. hearing set for Mr. and Mrs. John Jones versus Johnny Jones—petition alleging that Johnny Jones is mentally ill?

A I would hope that if at the end of this patient kind of exploration of the situation which I did in my office that I concluded that hospitalization for Johnny Jones was my recommendation—that I could then present that data to a court—I'm not saying that that data collection has to take place in a court setting—I don't think that . . . makes sense.

Q But then all of this that you have worked so hard and in such a careful manner to elicit will just simply all have to come out at 10:00 A.M. in the morning, accusations and cross-accusations among the family members, all to prove that [70] Johnny Jones is mentally ill?

A Well, if by ten in the morning you mean that it would be given short trift, I hope not.

Q I don't mean necessarily short trift, but that courts have calendars and they do things by calendars and that a hearing would be set, all the parties would have to be there, and it would proceed in that fashion—an examination, a cross-examination by lawyers, not by psychiatrists.

A That's right.

Q But you have never attended a hearing of that sort?

A In the commitment hearings that I have been a part of, yes, I was cross-examined.

Q No, but I mean where it was the commitment of a child.

A No, I haven't.

* * * * *

DIRECT EXAMINATION

BY MR. GOREN:

Q I just want one last thing, Doctor. In making a decision to hospitalize a child, is it important that the physician who is evaluating the child in regards to the necessity for admission be able to converse fluently in the same language that the child converses in?

A Yes, and I would add to that if at all possible, be familiar with the cultural background of the child.

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[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

[1] (Caption omitted in printing)

Deposition of DOCTOR DOUGLAS SKELTON, taken on the 3rd day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

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EXAMINATION BY MR. GOREN:

* * * * *

Q Do these physicians who make the decision to admit somebody to a hospital, have any kind of special training in making decisions whether or not to admit? Does your department give admitting physicians special training in making these kinds of decisions?

A In general the answer to that is no, that that special training comes through their own training and experience and those kinds of experiences that qualify them for licensure to practice medicine and surgery in this state.

Q Okay. Do any of these policies or regulations describe in detail what needs to be done before someone is admitted to the hospital, for instance interviews?

A No, they do not.

Q Do they describe what sources need to be contacted before you admit somebody, what kinds of information need to be received before a decision is made?

A They do not describe that, and if I could I'd like to describe why they do not. They do not because the act of admission is an act of medical practice, and the basis of that physician's training and experience in terms of obtaining their M.D. degree, their training, for example, in an improved training program [9] for psychiatry, for example, would include those kinds of—that kind of information that should be obtained in the clinical interview with the patient, what kind of information from other sources ought to be important in terms of that admission decision. So it would be my view that to promulgate rules and regulations for that would be an attempt on the part of me as an administrator in this sense, to practice medicine through other physicians who are duly licensed to practice in the state, and are duly responsible for their decisions.

Q So, because of that there are no written—written policies or regulations specifying what the admitting physicians need to do before admission?

A No, except in the sense that I mentioned earlier, that there are instructions clarifying what they law is in terms of admission.

Q Are there any standards in terms of diagnoses that physicians—admitting physicians in the regional hospitals use to refer to a particular condition of the patient that they're evaluating?

A I'm not sure what you mean by that question.

Q Is there a set of standards, a set of diagnoses, that admitting physicians generally refer to in diagnosing an individual's condition?

A They generally refer to diagnostic categories listed in the Diagnostic and Statistical Manual . . .

Q Okay. And that comes out in different editions?

A Well, there has been—the last one was called the Diagnostic and Statistical Manual Two . . .

Q Uh-huh.

A . . . which was an up-date of a previous publication which made [10] some changes in the diagnostic criteria classifications.

Q Do you know specifically what procedures admitting physicians use, what—what set things they may use in evaluating somebody prior to admission?

A My assumption is they approach it through an evaluation of what the presenting problem is, what the history of that presenting problem is, what the family

history is, what the social history is, what the history is of previous medical or psychiatric treatment, what the mental status exam conducted at the time would show, what reports would show from community agencies involved with this person in terms of either social or health needs in the community, and would supplement that with interviews or evaluations of significant others that would accompany the patient, either family members or concerned employees, or sometimes sheriffs, for example, would bring somebody in.

Q This is an assumption on your part, and an assumption based on what you assume they would have learned in their medical training and an assumption based on the fact of what they would do—what you think they would do individually, but not pursuant to any standards that the division has promulgated, is that right?

A That's essentially correct, although that assumption is made on a little more than that. It's made on the basis of my own experience at the Georgia Mental Health Institute and my awareness of what kind of practice is followed by the physicians there in terms of admissions, and general discussions I've had with other superintendents about these issues when they would come up in context of some kind of problem that we were addressing, and a general awareness that I have in terms of our [11] —our desire to develop a unified service system, which means involving the hospital and the communities together, so that we have urged that there be involvement between hospital staff and community mental health and mental retardation staff in terms of decisions to admit, so I'm aware of that general kind of push from my office level and through my staff over the hospitals and community programs. In terms of my direct experience has

been through the Georgia Mental Health Institute, that experience in the past.

Q And there are seven other regional hospitals in the state?

A That's correct.

Q Okay. You don't know specifically, for instance, how long an admitting physician in one of the regional hospitals would take to do an initial interview of a prospective patient prior to admission?

A No, I do not know, and I would—I would think that varies in terms of the nature of the problems and the difficulty in obtaining the interview—the material that's necessary to make a decision. I do know, for example, that the regional hospitals at Augusta and Savannah, as well as the Georgia Mental Health Insitute, are accredited by the Joint Commission on Accreditation of Hospitals, and they're—the things that they check the hospitals against would involve the kind of involvement between hospitals and community agencies in terms of that evaluation procedure, if there is sufficient documentation on the record to justify the diagnoses and treatment plan, or the actions that were taken.

Q And the remaining hospitals are not accredited?

[12]

A The remaining hospitals are not accredited by the Joint Commission, that's correct.

Q Have you or has your division promulgated any written regulations concerning informing voluntary patients of their legal rights?

A Informing voluntary patients of their legal rights?

Q Yes.

A That would be covered in the general material that I referred to earlier, which breaks down the requirements of chapter 88-4 and 88-5 of the Georgia Health Code in terms of what kind of forms, procedures, etcetera, must be followed for voluntary and involuntary patients according to either medical or judicial commitment laws, depending on which the county should select.

Q And these have been distributed to all of the regional hospitals?

A That's correct. All the regional hospitals, all the judges of Probate Court, all the district health officers, and the mental health mental retardation directors.

Q And what do these regulations say in terms of the actual informing of the patients of their rights, how is this done?

A Without looking at that statute I'm not sure I'm answering accurately, but I believe there is a notification given that has a certain mental health number that states your rights as a voluntary patient in Georgia's mental health facilities.

Q Are you saying the patient is given a form?

A Yes.

Q Do you know—do these regulations that you talk about provide that the forms be orally read and explained to the patient?

A My understanding of the requirements of law would indicate where the form cannot be understood that it be explained, where there's [13] some effort—some evidence to indicate that it cannot be understood, that it be explained.

Q Is there a notice given for a patient's right to file for a writ of habeas corpus?

A The notification of right to file for writ of habeas corpus is a part of the involuntary commitment procedure, that notice is given.

Q It's given to involuntary patients, it would not be given to voluntary patients?

A To my awareness it's not given to voluntary patients. They're not being held against their will. I don't know why they'd file a writ of habeas corpus to be released.

Q In your experience has there—have you ever seen a circumstance where a person is—who is labeled as a voluntary patient admitted to a hospital when he didn't want to be there?

A Well, I've seen, in the treatment of mentally ill and emotional disordered the same thing that you see in society in general, that voluntary acts have degrees of voluntariness in them. There may be certain coercion involved in—for example, the alcoholic, whose wife is threatening to leave him and take his kids if he doesn't avail himself of the treatment opportunity on the voluntary basis. He may feel somewhat coerced by that, but at least he's not coerced by me and the doctors. At least, I don't believe he is. I would say there would be degrees involved in how voluntary a person felt, depending on what pressures were put on him to seek treatment.

Q Is it possible to have a child or an adolescent come in to a mental institution under section 88-503.1, the voluntary [14] admissions statute, who didn't want to be there, and it's possible they could express that need, and yet they would still be admitted as a voluntary patient?

A That's correct. They would be admitted on the basis of the evaluation of the physician, that hospital care was indicated, and on the basis of the signature of their parent or legal guardian indicating that admission.

Q Okay. And are these children also given that form of their notice of their rights as voluntary patients?

A That right—that notice of right is given to whoever signs as the legal person responsible for their entry into the system voluntarily. So if it was a parent that signed the voluntary admission form it would be the parent that would have the right to indicate the desire for discharge within five days.

Q So you are saying that this form would not be given to the child, the child would not be notified of his rights to discharge as a voluntary patient?

A To my knowledge the child is not informed of it.

* * * * *

[16]

Q Can a child file a request like that?

A A parent or guardian would have to file the request for the child.

Q The child couldn't file it on his own?

A The parent or guardian is acting as a legal person in signing the voluntary admission. The parent or guardian would be notified of the right to request release.

Q Okay. Again, the child couldn't do it on his own?

A That's correct.

Q It would have to be his parent or guardian?

A That's correct.

Q The same parent or guardian who admitted him or applied to have him admitted to the hospital?

A That's correct.

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[44]

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EXAMINATION BY MS. KIRKLEY:

Q Would you identify Exhibit One, please, Doctor Skelton?

A A copy of my resume.

Q Okay. And is there anything that you would like to add to that?

A There are only two things that are not on here. I am presently a clinical professor of psychiatry at Emory University, and an examiner for the American Board of Psychiatry and Neurology.

Q Okay. Would you describe, please, the roles and duties of a [45] hospital superintendent?

A The hospital superintendent has general administrative and programmatic responsibility for the hospital services. In instances where that superintendent is nonmedical, there is a Chief Medical Officer or a Clinical Director or a Chief of Staff, referred to in a number of different terms, who would be the highest medical authority within that—within that hospital answering to the superintendent, then, for the quality of medical care in the hospital. The responsibility then involves the treatment programs through the superintendent or the chief of the medical staff, and the medical staff, there are a series of committees or responsibilities in terms of the adequacy of medical care. For example, there have to be

medical staff meetings periodically, there is required attendance of physicians, a certain percent. They—they lose their jobs if they do not attend on a regular basis. They are required to review certain records in terms of adequacy of care. They have . . . committees that address what medications are used within that institution. Medical records, procedures are also reviewed by that type of committee.

Q Would they be the individuals to establish policy with regard to admission procedures and periodic utilization reviews?

A Yes, those would be established through the superintendent's authority exercised through the medical staff.

Q And how do you see your role as division director . . . the superintendents?

A They are directly responsible to me for carrying out their responsibilities in terms of the overall institutional management [46] and hospital management. There are—there are requirements for such in the Joint Commission again that the superintendent or chief of the medical staff meet periodically with the governing board, and by their understanding I am the governing board, so we have quarterly meetings in which we discuss issues of concern to the entire state system, particular problems about the medical care, certain policies and regulations that have state-wide impact. For example, issues about convalescent leave which are addressed in the Georgia Code, that would be a topic for this kind of discussion. The question about setting admission policy, again, it has to be understood, that the administrator's responsibility to do with the technical requirements of law, that one has to be careful that the administrator who is also an M.D. is not

constraining the rights that an individual physician has to practice medicine under the Practice Acts of Doctors. To meet that act they are qualified to make certain kinds of decisions, and my judgment won't impinge on that process. We do have continuing education . . . for physicians, for other professionals in terms of keeping their level of expertise where all of us would like for it to be.

Q Are there particular local conditions that might mean different hospitals would have procedures different from other hospitals, for example, that if the two hospitals in Atlanta, because of community resources here might use different admissions process than hospitals in more remote areas?

A Yes. Hospitals in more remote areas, generally the older hospitals, have traditionally had—the state has, for example, [47] provided quarters for housing physicians so there are physicians on the grounds, and available on a twenty-four hour basis, while the other hospitals, the Atlanta Regional Hospital, which is not a residency training program, does not have a residency training program, they use a contract basis with physicians to cover the after-hours, weekend work. The Georgia Mental Health Institute, which has a training relationship with Emory University, uses second and third year residents in psychiatry as part of their admission process, so it varies to some degree depending on the availability of staff, affiliations that the hospital might have.

Q And again, perhaps, in somewhat more detail, what other responsibilities do you have besides overall direction of the seven regional hospitals?

A Well, for all the hospitals, the mental hospitals, the mental retardation hospitals. There are thirty-four or

thirty-five alcohol-drug programs across the state, community mental health centers in which we—the state provides money into these programs. We have foster homes, group homes, so I'm involved in the total system of mental care in the state, setting standards for group homes, for example, standards for family care, standards for community mental health centers.

Q In your first examination, you said that five of the hospitals are not accredited by the J.C.A.—J.C.C.H.?

A J.C.A.H.

Q J.C.A.H. Are they licensed by somebody else?

A They are licensed by the standards and license unit of the division of physical health for the department.

[48]

Q You stated that the act of admission is an act of medical practice?

A Yes.

Q Do you see any distinctions with regard to that statement between voluntary and involuntary admissions?

A Yes, I do. I see a distinction in the sense that the voluntary admission process is based on the evaluation in terms of the individual or client's need for hospital care, illness or disorder and a need for hospital care, where involuntary hospitalization is based on the presence of mental illness plus certain criteria in terms of dangerousness to self or others, for example under the medical commitment law, so that there are more stringent criteria on the physician in terms of involuntary commitment. It still is medical judgment whether to admit or not, but that judgment has to relate to dangerousness issues. The judicial commitment part of the law requires that when a

judicial board finds somebody in need of commitment, that they be admitted. In that sense we admit and evaluate and may discharge immediately if in our judgment they do not require admission because of their medical status, but I think there's a major separation in terms of the physician's responsibility between those two.

Q So are you saying there's a group of people who might benefit from hospitalization in the professional opinion of the medical directors, but would not meet involuntary criteria?

A Oh, yes, there's a group of people. In fact I would think that primarily people who are in need of treatment, hospital treatment, and who are unwilling to receive it, the large majority of those [49] do not meet dangerousness criteria, so we have that struggle with historical traditions of not only the state but throughout the nation, . . . people hospitalized if they should be in a hospital, there's no criteria—no specified criteria about dangerousness. In that regard, we refuse to admit, even though they need that hospital care but do not meet the dangerousness statute. And what we would attempt to do is try to persuade that person to either hospitalize himself voluntarily or to consult a community mental health center, or try to advise the family members of what other alternatives are available in that community should the identified patient change their mind at a later date.

Q Looking just at the group of mentally ill divisions serving, and not the mentally retarded, do you know whether or not as a rough estimate, more than half are being served voluntarily?

A The entire community program and the hospital program?

Q Including the community programs.

A The large majority are being served voluntarily.

Q Would you say seventy-five percent?

A Seventy-five to eighty percent.

Q Okay. You are familiar with the voluntary admission statute which says that a parent may apply for a child to be voluntarily admitted. Does the statute also provide that a ward may be admitted on the application of his guardian?

A Yes, it does.

Q Okay. And that would be an adult ward as well as a minor ward?

A Yes.

Q So might there be instances where a ward would say he did not want to be in the hospital, yet he would be admitted on the [50] application of his guardian?

A That's correct.

Q I think you described regional hospitals as being open hospitals. Would you go into some more detail about what attributes make them open hospitals?

A Well, what comes to mind in response to that question is that—twenty years ago would be a rough estimate of time—the mental health care system in this state and in other states was not well developed, and hospitals were generally isolated from communities. In many cases there were walls around the hospitals, so that they were in a sense what Goffman referred to as closed institutions. They are not that way anymore. They are open. They are open in the sense that visitors are regularly there, people from the community are coming in to participate

in programs, they are open in the sense that hospital staff go into the community, community staff comes into the hospital, and they are open in the sense that there has been increased attention to reversing the trend to lock initially and then release in terms of privileges, but to allow people the maximum freedom that they can handle under the circumstances. That's what's meant generally by an open hospital. It's a recognition that you cannot treat mental and emotional disorders without involvement in the normal everyday community life.

Q Do you know when Goffman did his work on institutions?

A No, I can't give a date on that, but I would like to point out that the title of that book is *Asylums*, and inside the front cover it says, "Essays on mental patients and other inmates." [51] "Essays" is not a scientific term. This was a participant-observer study, since it's his own value judgments about what he saw in the hospital, but it was done during the time when the open hospital concept had not permeated mental health practice in this state or in the country.

Q Have there been any more recent studies on the effects of institutions that are more like Georgia's mental health facilities?

A Well, there have been numerous studies that indicate the great pay-off in terms of improvement of the mentally ill, it has to do with the continuity of care between hospital care and community care for example. They—the kind of closed institution or closed society that Goffman talked about, that kind of thinking is reflected in sociology and stigmatization and labeling theory, the societal reaction theory as it was called at one

time. It's important to realize that that is theory. There is a difference between theory and fact. Chef is the sociologist who is primarily the—the person who feels most strongly that—that labeling or stigmatization are the important things in terms of deviants. For example, it's not individually determined, it's what people say it is and that—that influences that behavior to continue to. . . . Walter Gove of Vanderbilt, the sociologist, who holds contrary positions and has done in-depth research, not as a participant-observer, but asking patients what they think, do they feel stigmatized, and his research would indicate that patients are not homogeneous groups of people who respond like cattle, that there are many of them, over fifty percent in some of his studies [52] who indicate they felt positive about the hospital experience, do not feel stigmatized, that some of them improved their personal satisfaction, their role as provider for the family or as housewives. It is important to differentiate, I think, between theory and data, and there's significant data to question this theory. I think it's also important to note that psychiatrists and other mental health professionals are aware that there is a balance between what is individually determined, what's internal to that organism, physiological, psychological, and the impact of social factors, how other people respond—respond to that person, and you are in a sense evaluating both when you try to make a decision about what's the proper treatment, proper response.

NOTE: #905

Q You were present at Doctor Messenger's (phonetic) testimony?

A That's correct.

Q And Doctor Messenger testified with regard to the unreliability of psychiatric diagnosis. What is your opinion

on your reading and study with regard to the reliability of diagnosis?

A My opinion is it's much more reliable than Doctor Messenger indicated in his testimony. For example, if you take the major categories, phychosis, neurosis, personality character disorders, his studies would indicate anywhere from seventy, eighty-five percent, in those broad categories, maybe even better in some of his studies. If you look in a particular, say the major psychosis, for example, schizophrenia being a major psychosis, a major mental health problem in this country, there are cross national studies involving multiple countries where the data would indicate that there is an incidence rate of somewhere around [53] point three five percent of this disorder. There have been studies over the last ten years that indicate a significant genetic factor in schizophrenia. Now, for example, there would be four times the incidence of schizophrenia in the children of a family where one parent is a schizophrenic—biological parent is a schizophrenic. There are identical twin studies dating back to the late fifties, early sixties by Kollman that indicated that if identical twins are separated at birth, if one of those identical twins develop schizophrenia and the other one is tracked down, that there would be at that time, somewhere around eighty percent of the other twins would have schizophrenia. Those figures are now around forty-five or fifty-five percent, but if it's only stigma that identifies schizophrenia, then it's stigma that follows genetic patterns, that's a very interesting kind of stigma. There have also been studies, some of them cited in the Amicus Brief, studies that indicate difficulty distinguishing schizophrenia, which is a essentially a cognitive disorder from —from an out-patient disorder. The U.S. . . . case studies would indicate that British psychiatrists and American

psychiatrists would do very well in that regard. There are some studies for example, that indicate some difficulty in reliability on certain patterns of the test, but the overall end of that study said that the psychiatrists agreed almost a hundred percent on the diagnosis, so . . . bottom line . . . . There have been major advances in depression in the last few years in terms of distinguishing in a major psychosis or manic-depressive group, which clearly respond to a drug called Lithium. [54] There have—part of the revolution in mental health care has had to do with development of anti-depressants, for example, and there are ways to diagnosis the kind of depression that is more likely to respond to an anti-depressant medication. So obviously something is happening here that differentiates this group A that gets treatment B and improves, from general groups of people. It's like diagnosis in any field of medicine. It's not one hundred percent perfect, but the studies range from—if you're looking at observer agreement, then it would be fifty-five percent, if you look at some of them diagnostic concordance, then you'd see figures as high as eighty-five, ninety-five, ninety-seven percent in some of the studies, so it's not something you can make a global statement about, that all psychiatric diagnoses are unreliable.

Q Has—in general has the research in the last ten or fifteen years shown that diagnosis is more reliable?

A Oh, yes, it's shown that diagnosis is more reliable, and it's getting more specific as you develop more effective treatments. It was only in the mid-fifties that psychopharmacology was able to do anything major in terms of treating the mental illnesses. Medical history is that when you begin to develop from research a specific treatment approach, then diagnosis makes a greater difference.

The difference between British and American psychiatrists at one time in diagnosing schizophrenia and manic-depressive illnesses, it really made little difference because of treatment for the major psychosis, and they're both major psychoses, had to do with using major tranquilizers like Thorazine. When research began to indicate that in view of this [55] specific criteria you could separate off the manic-depressive with a bipolar affective disorder, and treat them with Lithium, then the specificity in terms of that diagnosis began to increase. The same thing has occurred in depression, for example.

Q Would this be true in medicine as well as in psychiatry?

A Oh, it's true across all medicine, psychiatric medicine or physical medicine.

Q You were talking about the adolescent unit at Central State Hospital and you stated that you had plans to merge the adolescent unit with the children's ward . . .

A That's correct.

Q . . . into . . .

A That's correct.

Q . . . the present children's building. Have those plans been made definite yet?

A Well, we're working toward a date in mid-December in terms of the use of the new hospital in Rome, the opening of the children's and adolescent's unit, which would allow us then to move those adolescents at Central State from that northwest Georgia area closer to their home, and would allow us then to combine the units, but it was a step-wise process involving Columbus and involving—and involving a reduction then of admissions of children

as well as adolescents, as children's services developed in the other regions, there were less children in our children's unit and less adolescents on the adolescent's unit, there was the opportunity for combining, and that effort has been on-going for some time as is reflected in the gradual reduction of both of those populations.

[56]

Q Has it been on-going since about the time of that study Mr. Goren referred you to, about the mental health services for children?

A That would date very close to it.

Q And would you expect that the merger would take place sometime in January, '76?

A If things go the way I expect them to go, I hope it'll take place before December ends. I might say that that process was speeded up when I visited the adolescent unit. I made it very clear that while I did not see that as an unacceptable, inhumane, totally destructive place for people to be, I did not feel that it was the most desirable of environments for adolescents, and requested of Doctor Philley and Doctor Zepatera (phonetic) that we begin to move as fast as we could.

Q We referred briefly in the first examination to the provision of legal services to patients. Could you state in more detail what you've done to provide legal services to the patients and what referrals were made?

A Well, I would think the thing that I've done that's been most important is essentially a sensitivity on the part of my office and me to issue the patient's rights. That sensitivity then, influences the whole system. In terms of specific things, the personal advocacy unit which

is a part of this division, was at the time I came aboard, has had my full support. They are essentially a central office staff who act in an . . . type role for patients who feel that they're not being—their rights are not being properly protected. There's a booklet, for example, entitled *Patients' Rights* that is given to all patients on [57] admission that shows in pictorial form and in simple English that should be understandable to all, what their rights are, and gives them the advocacy number so that they may call and indicate if they feel that one of their rights is not being respected. The hospitals also use the legal services offices around the state as a referral source when somebocy wants legal assistance. In the metro area they use things like Atlanta Legal Aid, and are encouraged to do so.

Q And what have you done at Central State Hospital?

A Well, not only the overall sensitization issues but in terms of working with Georgia Legal Services and providing them a place, an accessibility to patients and staff, and I feel that I've been as supportive of that process as it would be possible for a division director to be.

Q And you've provided space at Central State for a lawyer from the Georgia Legal Services, is that right?

A That's right.

Q And do you know how often a lawyer is at Central State from Georgia Legal Services?

A I believe that's twice a week, but I'm sure it's practical.

Q But in addition to the office there on the grounds of Central State, in other parts and in other hospitals, referrals would be made to the local legal aid office, is that correct?

A That's correct, or we would assist a patient in obtaining a private attorney, if that's what they wished.

Q You are also familiar with Doctor Messenger's testimony that judicial proceedings for the admission of children to mental health hospitals would have positive effects on the admission decision and on the child himself. Do you have an opinion in [58] this regard?

A It's my opinion that Doctor Messenger's view is not accurate. I would be personally concerned about the adversarial nature of that process, with the idea that cross examination of parents' right, a child's right, that does not seem to me to square with the parts of Doctor Messenger's statement that I accept, that it's the family system that needs to be looked at as well as the child or adolescent, and if that system is out of balance it may be necessary to hospitalize a member, and sometimes that member is not the child or adolescent. It may be one of the parents. But it seems to me that that kind of fact finding adversary kind of approach is not going to be conducive to proper mental health care.

NOTE: (Brief off the record.)

Q Do you have any special units within the division, Doctor, to handle children and adolescent services?

A It was established some months after I became the director, an Office of Child and Adolescent Services, which I not only established but recruited a child psychiatrist to head, Doctor John Philley, and have given full support to the development of more extensive community services for children and adolescents. That was one of the areas that was increased in our budget during the last year which did not fall during the special session of Congress, so that there's been a major effort on my part to

encourage the growth of alternative services in the community for children.

[59]

NOTE: (Brief colloquy.)

Q Are you familiar, Doctor, with any studies with regard to the effect of institutionalization on children, whether or not they're stigmatized by institutionalization?

A Well, there is a study published by the Vanderbilt University which was commissioned by the—the study was commissioned by the Department of Health, Education and Welfare, under Elliott Richardson, and the—Mr. Richardson's mandate was that they look at the supposed damaging aspects of labeling on delinquents, on mentally ill children, mentally retarded, etcetera. This is a study that involves probably a hundred and fifty people in the field, professional people of all disciplines, and it's entitled *The Futures of Children*, and there is a statement in that document that those people who wish to speak conclusively about the so-called stigmatized and labeling influences on children should speak with extreme caution, because the data do not indicate impacts, upon —significant impacts which can be substantiated on the identity of their sense of self. It should be the major work in the field.

EXAMINATION BY MR. GOREN:

Q Doctor Skelton, you said those facilities which weren't accredited were licensed by the state?

A That's correct.

Q The entire—each regional hospital is licensed by the state?

A It has a hospital license, a state hospital license.

Q Okay. Even for instance, the Walker Building at Central State is licensed as an adequate facility?

A Yes, it's licensed by the state.

[60]

Q Okay. Based on your view and the people that you've cited and the studies of stigma, are there people who in fact disagree with those views, other psychiatrists?

A Oh, yes, there are psychiatrists that hold with the stigmatization and the labeling theory. The distinction I was trying to make was between theory and scientific fact, and it appears to me that the fact does not substantiate the damaging aspects ascribed to stigmatization and labeling.

Q Are you saying that they're not as damaging as generally believed, but they are to some extent damaging?

A No, that wouldn't be an accurate interpretation of the way I put it. What I indicated was that psychiatrists and other mental health—mental health professionals recognize social influences on behavior as well as influences that arise internally, to a person, and how to look at those.

NOTE: (Brief off the record.)

Q Doctor, as far as your discussion about diagnosis, are there people, other psychiatrists that disagree with the—with the people that you cite in your opinion as a reliability on the validity of diagnosis?

NOTE: #1018

A Well, you can't disagree with a scientifically proven study. It's not a matter of opinion, it's a matter of fact in science, indicate—the studies indicate reliability to a certain degree. Now they may vary between—some

studies show very high reliability, some show less high, but an opinion is not really worth anything until it's backed up by some kind of data.

Q But if there was data to show this, then you would say there [61] would be disagreement?

A Well, there could be a disagreement, there could be a—there can be a problem on how certain data is interpreted. For example, as to whether certain other factors are considered in making conclusions about this kind of data.

Q Okay. You also said you were concerned about the adversarial process you thought would occur in a hearing. If a family has a child they want to try to admit to a hospital, isn't there already disruption in that family?

A Oh, yes, there's generally disruption in that family. The studies would indicate that the act of admission to a hospital whether it's an adult or a child, appears to be an act of last resort, that there are attempts to use a variety of social and health service agencies to try to handle the problem before people resort to request a hospital to handle that problem.

Q Are there cases where it's not used as a last resort?

A Oh, I'm sure there are times where people come to the hospital early in the process, but the studies would indicate just the opposite, that the act of hospitalization is an act that is not taken lightly.

Q What studies are you talking about?

A What?

Q What studies are you referring to?

A Oh, I can cite the studies, some of the studies of Gove, for example. There are a number of others I

don't memorize references, but I have them across the hall if you'd like to look at them. They'll be provided in the Amicus—answers to the Amicus Brief.

[62]

NOTE: (Brief off the record.)

Q Doctor, would any delay that might occur in an admission to a hospital due to a hearing prior to commitment in a non-emergency admission of a juvenile to a mental hospital be detrimental?

A Well, I'd be less concerned about a time delay than I would about the process that goes on in an adversary hearing, in a non-emergency circumstance then as long as it didn't sometimes delay the . . . while other alternatives were being explored. I'd be less concerned about the time delay than I would on the impact on that kind of procedure on the child or adolescent in the family.

Q Okay. You also mentioned in regard to services you provide a personal advocacy unit. Don't they also represent the staff in the mental hospital system?

A The—they are members of the staff, of the division. Their mandate from me is to try to act in a neutral objective fashion in terms of any complaints that are . . . to that unit. It is in my view inappropriate for the personal advocate, for example, to take any view initially that either the patient is correct or the staff is correct, and there have been times—there have been circumstances when it appeared to me that the advocate was taking more of the point of view that the staff are wrong. It seems to me that the staff primarily respond in good faith as do patients. What's needed is as objective an evaluation as is possible, in an attempt to be of assistance.

Q So that unit, then, does not solely represent the rights of the patient, am I correct? It's more of a neutral position as [63] opposed to solely representing the patient.

A Represent the rights of the patient as opposed to the rights of the staff?

Q Yes.

A I don't think they look at is as an either-or kind of situation to them. If it's clear to them that the patient's rights are not being respected, then they represent the patient. But usually things are not that clear in the everyday world of trying to take care of the mentally and emotionally ill.

Q You also referred to Atlanta Legal Aid. Haven't they stopped taking referrals from mental hospitals because of their case load problems?

A I think that's true. I don't know that for a fact.

Q Are you familiar with the case load problems of the Georgia Legal Services offices throughout the state?

A I understand from what I'm told by Georgia Legal Services that they're innovative. (Laughter.)

Q Can you just explain to us what the function of the Office of Children and Adolescents is?

A Well, at the time that I became a division director there was one staff member and a district nurse who was the primary central office focus for the development of child and adolescent services. It had only been a year prior to that that the first appropriations specifically for community services for children was in the budget, although there had been services developed out of general adult funds. There was a need for someone that had not

only an awareness of the needs of children—needs for child and adolescent services, but also someone that had a public health [64] commitment of a similar nature to mine to assist in utilizing those new resources that were being made available in the proper way for child and adolescent services, and that's Doctor Philley's role, in terms of assisting local community programs and developing new child and adolescent services and assisting hospital staff and their programs of treatment. He exercises that role through personal contact, through quarterly training sessions with the child and adolescent staff from all over the state, hospital and community staff. So it was a perceived need on my part to recognize, as I do, the specialty area in terms of services for children and adolescents.

Q Okay. And is that office also going to—are you going to establish an advocacy unit for children?

A The present advocacy unit operates across the entire spectrum of disabilities. . . .

Q How many people are in that unit?

A There are three full time staff assigned to that unit.

Q And they serve the entire state?

A They serve the entire state. Certain of the hospitals will have identified staff members who are assistants who will be designated to work with them in terms of those hospital programs.

Q Okay. Finally, are you familiar with Doctor Zepatera?

A Yes, I know Doctor Zepatera.

Q Do you think that there is difficulty in communicating, or there may be difficulties in Doctor Zepatera's communicating with others, in particular her patients?

A I've only had close contact with Doctor Zepatera since this [65] case was filed. My own view is that she handles the English language quite well and seems to be a very sensitive psychiatrist.

Q And you don't see any difficulty with understanding her?

A I've had none.

Q And you have not had any experience where she's had any difficulty understanding anybody else?

A She didn't have any difficulty understanding me.

Q Okay. No further questions.

END OF DEPOSITION

* * * * *

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR DONALD G. MILES and DOCTOR WILLIAM WIELAND, taken on the 4th day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

For the Plaintiffs: GERALD R. TARUTIS, ESQ.
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[2]

MR. GOREN: The stipulations and all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The signature of the witness was specifically waived by his attorney of record, DOROTHY Y KIRKLEY, ESQ.)

DONALD G. MILES, HAVING BEEN DULY SWORN AS A WITNESS, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

Q Would you state your full name for the record, please?

A Donald G. Miles.

Q And where are you employed?

A Georgia Mental Health Institute.

NOTE: (Defendant's Exhibit Number One was marked for purposes of identification.)

Q Would you identify Exhibit Number One?

A That's my curriculum vitae.

Q Okay. And you have a Doctorate in rehabilitation counseling . . .

A Yes.

Q . . . is that correct? Would you explain what the duties of your position at G.M.H.I. are?

A All right. In a nutshell, they are the general administration of the institute as one of the state's regional hospitals that serves twenty-six northeast Georgia counties, and I also chair the northeast Georgia Mental Health Consortium, which is G.M.H.I. [3] and four community mental health centers that join together in partnership to provide the mental health services to this region.

Q Now, the four community mental health centers, do they serve all counties within that area?

A Yes, we're totally contiguous, the four centers and

G.M.H.I.'s boundaries are the same. The four of them together are the same as the total G.M.H.I.

Q Do the four centers have satelite offices?

A Yes, they do.

Q Is there a satelite office in each county?

A No, not in each. In some of the smaller counties they may share between two or three counties in a centrally located one, but there is some fairly accessible, even in the counties with only three or four thousand population.

Q Does G.M.H.I. and the four community health centers serve children and adolescents?

A Yes, all four centers have children and adolescent service programs, as does G.M.H.I.

Q Okay. We asked you to get together some information on admissions of children to G.M.H.I. since 1969. Have you got that data with you?

A Yes, these are five years of data.

Q Is this the same thing or is this continuous?

MR. WIELAND: One is for children, one is for adolescents.

NOTE: (Defendant's Exhibits Numbers Two and Three were marked for purposes of identification.)

Q Would you identify Exhibits Two and Three, please?

[4]

A All right, Exhibit Two is the printout of the last five years of patients discharged from the adolescent unit, and Exhibit Three is the printout of the last five years of

patients discharged from the children's unit, including admission date and discharge date, diagnosis, type of admission, who admitted them and who they were released to.

Q And who prepared these, Doctor?

A Our patient information office, medical records office.

Q And do you have information on your current patients?

A Yes, we have social histories and some intake information on each of the current residents of those two units.

NOTE: (Defendant's Exhibits Numbers Four and Five were marked for purposes of identification.)

Q Would you identify Exhibit Five—Four?

A Exhibit Four is the mental history, including some social history on the patients currently resident in the adolescent unit.

Q That's for each patient individually, is that correct?

A Yes, each patient individually. And Exhibit Five, is the same information for all of the resident patients on the children's unit. The dividing age between those two units is approximately age thirteen.

Q Now would you describe, please, the admission process for children to both the children and adolescent units?

A All right. And I do have a written policy statement on that, but I'll summarize briefly what that is. We have so organized our regional mental health services that the ordinary and usual method of admission is to apply to the

community children and youth service program in each of the four community programs. The staff there then do a preliminary evaluation and develop a [5] plan of action. This will include contacts with the teachers, the parent, if there is a court involved, with the judge, and any pertinent parties involved in making the decision. Probably only one in a hundred children referred is referred on to G.M.H.I. for hospitalization. The intent is to provide community services wherever feasible, and only where either a complex diagnostic situation exists, or where there is no possibility of providing the needed treatment while the child is living at home would the referral be made to G.M.H.I. But when they—the child actually arrives at G.M.H.I. there has, in most cases—I'll tell you about the exceptions in a moment—but in most cases, been this advance evaluation and planning and either telephone or in-person contact between the community child and adolescent staff and the hospital child and adolescent staff, so we're fully informed, I'm sure. But with the children's unit, I asked the unit director recently about that, she could think of no child in the last year that had not been previously evaluated in the community. The adolescent staff has about one every month that was not evaluated in the community. The ones who are not, and essentially are, therefore, by-passes of our system, come in and are seen by the—in this case it would be the adolescent staff since this doesn't happen in the children's program—are seen by a staff member, including the child psychiatrist if it's daytime hours, or the psychiatric resident if it's nights or weekends for an evaluation. Also by telephone the on-call person in the community program is contacted, and any information they have or can obtain withan an hour or so while the proposed patient is waiting is pulled together, and then a [6] decision is made

whether or not to admit based on both the interviews made and the information that can be obtained from the community.

Q These adolescents that are admitted without going through a community program, are they voluntary admissions or court ordered?

A They are usually voluntary. The court ordered ones we usually have advance notice from the judge. We've been working with the judges sufficiently that in most of those cases the judge has made advanced contact with us and we have had a community staff member consult with the judge.

Q In cases of direct admission, what sources of information would the hospital staff go to to find out about the history of this child?

A There are—now this is the case of the non-community transfer case . . .

Q Right.

A . . . the one who walks in—however he gets there.

Q Right.

A Okay, well, in addition to the interview with the adolescent, himself or herself, there's usually somebody that's brought them, a parent or a relative or a friend is usually involved, so there's an interview with whoever brought them. Then the telephone contacts to the community program asking them to investigate. About half the time the community program know the child and can immediately say, "Oh, yes, we've been working with them and here's what the plan is," and, "Yes, we do think it's all right for you to admit," or "No, we don't," and, "He's just running away from our treatment pro-

gram, send him back." Sometimes we're [7] not able to find out any information from the community people. There will be a phone call made to the family physician, to the parents if they aren't with the child, any logical source to try to understand what is bringing this child to the hospital.

Q Do you have written policies on admissions?

A Yes.

NOTE: (Defendant's Exhibits Numbers Six and Seven were marked for purposes of identification.)

Q Now if you would identify those next two exhibits.

A Exhibits Six and Seven are the Georgia Mental Health Institute's admission policy, which is the formal statement of that general summary that I gave about how patients of all ages would be received at the institute. It doesn't specify children, but the policy is the same for all age groups.

Q Who issued this policy?

A I did.

Q How long have you been superintendent?

A Three years in March.

Q And do you have any special policies relating to the admission of children?

A Yes, we have a general statement. We had a committee getting together to plan all of the details of this general policy, how will that work specifically for children, and that was set forth and all of its sub-objectives and responsibilities assigned for people who would see that what I have said really happens, and this, which I sup-

pose you'll want to admit, is the statement of those policies and objectives for children specifically.

Q And did you issue that policy statement as well?

[8]

A Yes. Yes.

NOTE: (Defendant's Exhibit Number Eight was marked for purposes of identification.)

Q And Exhibit Eight is the memorandum we've been discussing about the application of these policies to children and adolescents . . .

A Yes, it is.

Q . . . is that correct? In your community programs and also when a child is admitted to the hospital, is any provision made for the joint treatment of the parents or other members of the family?

A Yes, it is, and one of the policy statements in there is the—is that that will be done and it outlines the method whereby the decision will be made as to who will be working with the parents, so that in every case someone will be working with the parents, and there's a mechanism for deciding whether it's the community program or the hospital staff or both who will do that.

Q Can you summarize that?

A All right. Well, that is part of the negotiation at the time of admission, and that—the decision is based generally on what looks like the discharge plans for the child, so that if it looks like we have an intact home and the child will be returning home and there will be a continued treatment plan, then it's likely that the community staff will do the work with the family if we're to keep that

continuity going. They may come to the hospital to do this, and the hospital staff may join with them in doing that, but on the other hand if the family is not intact and this is a D.F.C.S. custody case, then it may be that whatever contacts can be made with community people will be done by the [9] hospital staff, but in every case it's negotiated at the time of admission and written in the treatment plans as to who is going to be doing what.

Q What about in community treatment before a child gets to the hospitals, would the parents also be involved on that level?

A Yes. Yes, all of our community programs are very much family oriented. Whenever there is a family included in treatment, the method is family therapy.

Q Is there any way that you require parents to have therapy?

A Yes. Sometimes they won't agree, but we try to contract, literally, with parents to participate in the treatment of their child. Many parents like to do this because we have methods of training parents in how to better deal with their children, and most of them are eager to learn how to be better parents, so that is not a frequent problem in getting them to participate in these programs.

NOTE: (Brief off the record.)

NOTE: (Defendant's Exhibit Number Nine was marked for purposes of identification.)

Q Okay, Doctor, would you describe Exhibit Nine, Please?

A All right. Exhibit Nine is a count of the number of children and adolexcents since July 1 of 1967 who have

been seen at the institute and evaluated and indicating then, which ones were rejected for admission, or how many of that total were rejected for admission. Since we reorganized and shifted the responsibility for making those decisions to the community program in '73 and '74 and '75, we have stopped keeping the information, although [10] as I mentioned earlier there have been a handful, but we didn't have the record system to indicate how many there were.

Q Prior to '73 you were evaluating children and adolescents first? They had not been through a community program?

A There were all evaluated at the institute up until '73.

Q Now this list for '71 through '72, it just shows the number evaluated?

A Again, the records—we didn't keep the records of that, although that did precede the reorganization. The pattern in '70 and '71 and those prior years would be predictive of '71 and '72 also.

Q You were using the same system . . .

A Yes.

Q . . . in '72 and '73?

A Yes. It wasn't until '73—mid-'73 that the system changed.

MR. GOREN: When you refer to the system, is that the community based . . .

A Community based evaluation.

MR. GOREN: . . . the idea that those people would be admitted—adolescents to the community first, is that what you're talking about—that change?

A Yes, that change took place in mid-'73. Prior to that time they were all evaluated at the institute.

NOTE: (Brief off the record.)

NOTE: (Defendant's Exhibit Number Ten was marked for purposes of identification.)

MR. WIELAND: See, the institute didn't become our regional hospital until 1973 . . .

[11]

Q Would you identify Exhibit Ten, please?

A Exhibit Ten is a proposal which was endorsed just yesterday by our Regional Management Consortium Committee, which takes one of the objectives from a previous exhibit, Exhibit Eight, having to do with the responsibilities for longer stay children and the placement problems of longer stay children, when it's time for them to return to the community. That gets very specific on how that will be done and establishes a review mechanism so that cases that stay beyond three months will be regularly reviewed to determine what work is being done by whom and what the progress is toward making a placement.

Q This is with specific reference to placement back in the community?

A Yes.

Q Who would be involved in that planning and review?

A The committee that does that is a combination of staff from the four community programs and from the children and adolescent units. They get together and jointly do these reviews and make the decisions.

Q How often are reviews made past the three months?

A Well, periodically. Every three months on these long stay cases, they will do a review,

Q Do you have a general policy in the hospital for the review of all patients?

A Yes. That would apply also to these long stay and also to the shorter stay patients, but there is regular peer review mechanism and then a hospital-wide review, services review committee that reviews these cases regularly.

Q Do you have a written policy on periodic review for the whole [12] hospital?

A Yes, we do. This is our written and approved utilization review plan, which again is for all age groups but does apply to the children and youth.

NOTE: (Defendant's Exhibit Number Eleven was marked for purposes of identification.)

Q And Exhibit Eleven, Doctor, is the utilization review plan for the whole hospital, is that correct?

A Yes, it is.

Q Did you issue this plan?

A Yes.

Q And it's dated November 7th, 1975?

A Yes.

Q Was there a plan in effect prior to this one?

A Yes. Yes, this meets some new Federal requirements, so it's really a revision of the previous plan.

Q Does it have any specific time deadlines in which cases have to be reviewed?

A Yes, it does. If we could turn to Doctor Wieland,

who chairs this committee, I think he can give you more accurate information.

DOCTOR WILLIAM WIELAND, HAVING BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

A We put in the general policy that our cases have to be reviewed at least within the first thirty days—they are reviewed right after admission and then within thirty days. The first review is to look at the appropriateness of the admission in the first place, and the second review is to look at the length of [13] time and whether that's appropriate. In practice, we're actually reviewing cases after twenty-one days.

Q Who would make this review, Doctor?

A The service review committee meets once a month, and the medical records reflect cases who've been in the hospital for more than twenty-one days.

Q Who is on the committee?

A It's—involves all disciplines, a representative from each adult, alcohol and drug, and children and adolescent unit, these people may be social workers, nurses, or mental health workers. It also includes two physicians, and the Director of the medical records.

Q And that committee meets once a month to review all patients?

A Yes, and then all the longer stay patients are also reviewed by another physician from another unit who then further makes a determination whether longer stay is appropriate.

Q Are there any particular additions to that with regard to children, or is the policy pretty much the same?

A No, this particular policy is the same for both children and adults.

NOTE: (Defendant's Exhibit Number Twelve was marked for purposes of examination.)

Q Doctor Wieland, is Exhibit Number Twelve your curriculum vitae?

A Yes, it is.

Q Is there anything you want to add to that, or is that up to date?

A No, it's a recent one.

NOTE: (Brief off the record.)

[14]

EXAMINATION OF DOCTOR DONALD G. MILES, CONTINUED:

EXAMINATION BY MS. KIRKLEY:

Q Now, Doctor Miles, after you've reviewed a case, and it appears that it's time for a child to try to be placed back in the community, do you find that you have substantial problems with natural parents who refuse to take their children back?

A That is a problem area. It doesn't happen in the majority of instances, but it only takes say one out of every twenty, to, over a year or two accumulate a group where we do have troubles, and that is a—therefore a significant problem, where we have families who have lost interest or willingness to work with us and with their children. We have even had a couple of occasions where they moved out of state to avoid responsibility for taking their children back again.

Q What steps do you take when you see this happen?

A We've done some detective work to find out where they went and get in touch with them and try to determine whether or not there is any prospect for there taking their child back. Now, when they have gone to those lengths, it's usually a good indicator that we shouldn't be placing the child back with them anyway, in which case we work with D.F.C.S. to transfer custody, and worked out a foster placement for these types of children.

Q D.F.C.S. is the Department of Family and Children's Services . . .

A Yes.

Q . . . in the county of residence, is that correct?

A Yes.

Q So you have a relationship with D.F.C.S.?

[15]

A Yes.

Q A continuing relationship to refer cases to them as necessary?

A Yes, we do. Again, this is jointly the community program and the hospital staff who make these arrangements. The community staff keeps that liaison with the D.F.C.S. office wide open.

Q You are familiar, Doctor, with one of the claims in this case, that judicial proceedings should be used prior to the admission of children to a hospital on the application of their parents?

A Yes.

Q In your opinion as superintendent of G.M.H.I., would judicial proceedings in all voluntary cases improve the admission process?

A I don't see how they would. We have tried to be as thorough as possible. We've philosophically felt that we needed as many people involved as possible and as thorough a community evaluation as possible, and I think we've done it, and I don't believe that that would add anything to the decision making. I think it might, in fact, prevent some children from getting into treatment as early as they should in some crisis situations.

Q That's all the questions I have.

EXAMINATION BY MR. GRANBERG:

[17]

* * * * *

Q And are there any rules, policies, etcetera, in regard to the items or the subjects to be covered in the interview other than the basic information which is mentioned on page three of this policy?

A There are no formal policies on that. There is a fairly standard kind of approach that any clinician trained to work with children would use and is trained to use, but that is not a matter of policy.

Q Okay. Who actually does the admitting? Who is qualified, all physicians?

A Yes—well, yes. Although we have a child psychiatrist who has had training beyond the general psychiatric residency in child psychiatry, who is assigned to these two units, and will be providing that. By law any physician can do it. In our case it is a physician who happens to be a child psychiatrist.

Q So the child psychiatrist is the one who makes the ultimate decision for admission?

A Yes, unless it's night or weekend admission, and since most of our admissions are planned for this age group, that is rare, but it's possible that it would be one

of the psychiatric residents in the Emory training program who will do that. [18] They are fully licensed physicians, but occasionally it's not . . .

Q Sure. I should also say that when I'm talking about admissions, I'm only—unless I say so, it would be non-emergency admissions, okay?

A All right.

Q I'm sorry I didn't clarify that. Are there any policies in regards to location of the psychiatric interview?

A No. The location, if it arises at G.M.H.I., the situation is one that's presenting there, and has not been screened in the community—or has been screened in the community, in either event, the next step is on the unit, in the office.

Q It's always in the child psychiatrist's office?

A Or it may be in the social worker's office, the chaplain's office, there is an inter-disciplinary decision that's made.

Q There—you mentioned the use, when it's referred from the community, of secondary resources, namely schools, I think you mentioned specifically . . .

A Yes.

Q . . . and interviews with other people in the community. In regards to the community and the use of those secondary sources . . .

A Yes.

Q . . . are there any types of methods or policies utilized in existence in the—through your office which provide for verification of those secondary sources, . . . information from those secondary sources?

A No, if they are reported on the transfer sheet from a community program, we accept their word for it that they have made the [19] contacts that they say they have.

Q And if it's not referred from a community mental health center, then is there any way—any policies as to—psychiatrists or the admitting physicians, obtaining information by secondary sources?

A Yes.

Q And . . .

A As I mentioned there will be—if it's not a referred case by the community program, there will be a telephone check while the child is waiting, to find out as much information as possible, but sometimes it takes a day or two to obtain a full report, so they get enough to try to make a proper decision, but then it's another day or two before they can verify it, which is sometimes directly themselves, and sometimes by the next day having the community staff make a visit to whoever is involved and report back to them.

Q In that period—in that interim, where is that child who is sought to be admitted?

A All right. If the initial evaluation indicated that there was a reason to be admitted, he would be admitted while this was taking place. If they could find no reason to admit or no reason not to treat in the community, then they would send him home.

* * * * *

[21]

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Q But again—okay, maybe we should define an emergency situation, because I'm talking—I realize your concerns with crisis situations. It's also very important,

and we share that, but we are talking about—all of the questions I'm referring to, we're talking about non-crisis and non-emergency situations. Maybe, if you would, just define what you consider to be an emergency or crisis situation?

A All right. It may be a crisis because of the child's illness or it may be a crisis because of the family's circumstances. The latter occurs probably more frequently than the former. If it's the child that's having a crisis, in fact we can often treat them at home, because the home is more likely to be stable, but if it's the home, you know the father is in an alcoholic rage and beating the mother and the kids, which is a fairly typical circumstance, the urgency of removing the child—well, some intervention is done with that family.

Q So it's basically a situation involving—please, I don't want to overstate it, it's basically a situation involving danger to the child, a crisis situation?

A Yes, very often, uh-huh.

Q I'm also—I realize sometimes when lawyers and psychiatrists talk, there's certain terms that engender bad responses like medical determinations, professionals, and when we say things like liberty and—sometimes there's feelings of conflict between those. I—just listening to you talk, though, I'm sure that your concern for liberty, the rights of liberty of a child are [22] evident, and it seems to me your institution has made that especially clear in its desire to implement policies, making sure that no child is institutionalized incorrectly or unnecessarily.

A Yes.

Q Okay. Considering that and the other things that we were just talking about, if—would you find it unduly burdensome if all this information that's available, could be gathered, and representatives from different groups, namely psychiatrists, social workers, child care workers, D.F.C.S. workers, your community mental health people, could present all this information together to an independent arbiter, even perhaps a judge, a Probate Court Judge, a Juvenile Court Judge, or some other person, would that unduly burden the functioning of the hospital?

A I don't—I don't know. It would probably depend on how that was done since we—we attempt to gather that kind of information anyway and feel that it's proper to be that thorough in making these kinds of decisions, so if that could be done without staff having to leave their jobs to go do this, and if the material could be transmitted as readily as we're transmitting it now, then that should not be too burdensome. I guess I would be concerned that it might turn into a big paper procedure.

Q Surely. But if all the people got together who had some information on the child, wouldn't that enhance the likelihood of a valid diagnosis, if all this information was exchanged, and also not only increase the validity of a correct diagnosis and treatment plan, but also the information as to possible existing alternatives that perhaps, individually or even in groups of [23] one—one on one conversations hadn't been thought about?

NOTE: #550

A I suppose as a general rule of human affairs that more heads are better than a few heads, and that's true. I do feel that we have recognized that, and I would be surprised if we very frequently found anything that we were not already on top of, because—obviously we're

sharing similar philosophies, that we need to be very careful to protect these children and to plan carefully so that their futures are not marred by unnecessary hospitalization.

Q Your testimony on direct examination and now just what you're saying again here, seems to indicate that—that you are cognizant of what—the potential conflict of interest between children and parents, is that correct?

A Yes, there is a potential that will occur in a certain number of cases.

* * * * *

[25]

* * * * *

Q Do you have any written policies, procedures, guidelines, [26] written or non-written, that deal with any notice of legal rights to the child that is admitted under the statute?

A I don't know. I don't believe there is anything written, and the—we do have a written procedure for notification of rights to all patients of all ages, but the reason I would answer "I don't know" is that for a four-year-old, I'm not sure how that's handled.

Q So you're not sure whether the child is either informed orally or in writing?

A That's right. They may tend to be done more with the parent or guardian than the child, which would be my hunch as to the way that policy is being applied.

Q And the parent or guardian who receives that information, may, as we previously talked about, have a potential conflict of interest with the child?

A Yes.

* * * * *

[33]

* * * * *

Q What is the name of that committee?

A The Youth Services Review Committee. So we have felt if they're there three months, it's time to get alarmed, and do a formal review including community staff to be sure that hospitalization is proper, and that if it's not and they're there simply because they need a place to live, that somebody is working on it.

Q And then those reviews continue . . .

A Every three months.

Q . . . every three months after that. Okay, the immediate review that's done after admission is done by someone not involved with the admission process?

A Yes.

Q Someone different? Who would that be, a physician?

A Well, there's an admission review officer who is not a physician. Those—this is done in accordance with H.E.W. guidelines on review and there's a set of criteria indicators for admission and the review officer just looks at the record and determines whether or not the criteria were met, did the staff apply the criteria in making their decision, and if not, then Doctor Wieland is notified and he gets involved as a physician in determining why the admission was made.

Q And the second one is done within twenty-one to thirty days, who is that conducted by?

[34]

A All right, that is a peer review—interdisciplinary peer review. A physician other than the physician who admitted makes the recommendation as to the necessity for continued hospitalization.

Q Okay. And then after three months there is a Youth Services Review Committee.

A Yes.

Q And that's composed of the—the child phychiatrist committee?

A Well, it's staff from both of those two in-patient units and the four community programs, but does not include the child psychiatrist. The child psychiatrist makes recommendations to them, but . . .

Q The child psychiatrist is the one who is responsible for that child . . .

A Yes, he is in charge of the case, but by that time there is often a placement problem involved, and that's not really a psychiatrist's job. So her recommendations go to that group. The group itself is more likely to be the people who can move the case.

NOTE: (Brief off the record.)

Q Does H.E.W. guidelines apply to all regional hospitals?

A Yes, they do.

Q Okay. I'm just a little bit curious about this Youth Services Review Committee. Are you saying that after the three months—the child psychaitrist is not even at the first meeting after the first three months?

A Not at the meeting.

[37]

* * * * *

Q Now, again, considering your obvious concern with the children, treatment, not being hospitalized where they don't need to me, and also your concern with just—

it seems to me your—a basic civil liberties approach, that a child shouldn't be confined as a matter of law if he didn't need to be, would it be unduly burdensome to have someone independently appointed as an advocate for the child, not so much to fight everything that's being done, but to serve as a representative for the child, trying to represent his best interest—what he considers to be the child's best interest?

[38]

A Obviously I'm pausing because I—kids do get caught in the awful complex webs of situations, and the more that there can be advocacy and thought on their behalf, the better, and I wouldn't argue with that principle at all, it's that I suppose every administrator gets caught in—also bureaucratic procedures that sometimes stifle the very thing they're created to correct, and whether that would do that or not I don't know. I'm in favor of it in principle, though I would need to know what the mechanisms are.

Q Sure. I have no further questions.

EXAMINATION BY MS. KIRKLEY:

Q I just have one question. You talked about parents contracting with the community mental health centers to have family therapy.

A Yes.

Q Do you have any idea of what percentage of parents do contract?

A The majority. Almost all. It must be at least ninety-five percent.

Q That's all the questions I have.

END OF DEPOSITION

* * * * *

EXHIBIT 6

GEORGIA MENTAL HEALTH INSTITUTE HOSPITAL SERVICES

Patient Admission and Evaluation
from the Geographic Service Areas

POLICY 430-2 July 2, 1975

1. **PURPOSE:** To establish criteria and general procedures for the appropriate movement of clients from designated geographic service areas to the specialty services of the Institute.

2. **POLICY:** The Institute and the Geographic Service programs of the Northeast Georgia Mental Health Consortium will operate 24 hours a day, seven days a week as a unified mental health service system to provide appropriate, balanced mental health services to all persons living within the areas served by the Consortium. In particular, all criteria and general procedures stated in this policy are regarded as mutually binding upon all parties served by the system. As a unified service system, the Consortium regards explicit referrals from Geographic Area personnel to the Institute as legitimate transfers between programs within the balanced service system. An "explicit referral" is made by an area staff member who has personally conducted an intervention with and assessment of the client, resulting in a certification by the Area's mental health staff that all levels of care criteria, as well as legal requirements for admissions have been met and that no appropriate alternative resources are available within the client's geographic area.

3. **PROCEDURE:** The following general procedures regarding admission to the Institute are broadly appli-

cable throughout the Consortium. Specific variations must be in writing and jointly approved by the Superintendent, the Deputy Superintendent (Medical), and the appropriate Area Mental Health Director(s). Such variations, and other amendments approved in the same manner, must be reviewed by the same persons quarterly (on the 10th day of July, September, January and April) and rescinded when no longer applicable.

a. Persons **explicitly referred** by staff of an Area Mental Health Service **shall** be admitted to the Institute under circumstances (1) and (3) **or** (2) and (3) below:

INTRA-OFFICE COORDINATION

TITLE	INITIALS	DATE

(1) Person has been seen and evaluated by Area staff; and if a voluntary applicant, he/she arrives with service objectives agreed to by the Area and Institute staffs. The person must be willing and capable of signing a voluntary admissions form.

(2) Person arrives from a judicial county with appropriate legal authorization for non-voluntary admission and, when possible, prior notification by the area staff with service objectives agreed to by the two staffs.

(3) Person arrives during "normal working hours" (8:00 AM-4:30 PM, Monday-Friday, except holidays) unless another arrival time and date has been arranged **or** person arrives as an emergency admission authorized by a physician.

b. Other persons arriving from medical counties with legal orders for evaluation or recommended admission must be evaluated by the Institute staff who are under the supervision of the Deputy Superintendent (Medical), with a disposition arrived at in accordance with all applicable laws, facility policies and criteria.

c. Other persons (walk-ins, bypasses) not explicitly referred to the Institute by geographic personnel must be screened by the Institute Admission and Evaluation Unit to determine appropriateneness of hospital admission. Persons residing within the service areas of the Consortium will, on arrival, be brought to the attention of geographic personnel (through agreed upon on-call procedures) and shall be directed to appropriate alternative services within the geographic area at the earliest available opportunity.

d. When the area mental health staff determines that a client requires hospitalization, the Admissions and Evaluation Unit will be called and given the following information:

(1) Personal identifying data (name, age, sex, address, phone number, county of residence and mental health catchment area).

(2) Current situation, reason for hospitalization, and commitment status.

(3) Objectives to be reached during hospitalization or evaluation.

(4) Date for which admission is recommended.

e. Admissions and Evaluation will determine whether the patient needs physician's screening and unit of assignment.

f. Voluntary Admission. The Admissions and Evaluation Unit will interview the client and its clerical staff will record on single sheet of Admission Summary (MR 100) with three carbon copies (for Medical Records, ComCenter and Patient Accounts) information as follows:

Name, present address, telephone number, age, nearest relative, person to notify in emergency, patient's representatives, marital status, employer, income, hospital insurance information, and referral source. Plus:

(1) Obtain signed Consent on the reverse side of the Admission Summary sheet.

(2) The Clinical staff will serve the individual notice of Voluntary Rights as a patient and give or send copies to the patient's representatives.

(3) Make or correct addressograph plate. (Include current date and unit).

(4) Stamp 3 x 5 Notification cards and Dictation card.

(5) Stamp routine Lab and X-Ray requests.

(6) Notify unit that the patient is on the way.

(7) Complete MSIS Computer Admission Summary sheet.

(8) Complete insurance papers.

(9) Take picture of the patient.

g. Involuntary Admission. The procedure is the same as above with the following exceptions:

(1) If a person is requested to sign a Consent for Treatment form and does not or cannot because of his/her condition, and meets voluntary criteria, a physician must involuntarily hospitalize the person by signing forms MH 1013 and MH 1014 or MH 2013 and MH 2014. The person must be given an explanation of rights as an involuntary patient.

(2) If a person is accompanied by judicial papers, he/she does not have to be evaluated for admission by a physician, but is admitted. These forms are MH 1026 and MH 1027 or MH 2026 and MH 2027.

h. In the event of disagreement between the Institute and other Consortium personnel regarding a particular admission to the Institute, normal supervisory channels should be utilized to resolve the disagreement. Whenever possible, the patient will remain at the Institute until the disagreement is resolved. Ultimate authority to refuse admission rests with the Deputy Superintendent (Medical) or designee whose explicit intervention is required if other agreement is not reached within 24 hours of the prospective patient's arrival at the Institute.

i. All admission procedures applied to 1) mentally ill persons and 2) alcoholics and drug dependent individuals must be in compliance with Georgia Health Code 88-5 and 88-4 respectively, as currently amended. Supervisory personnel having responsibility for the admission and evaluation of clients are expected to be familiar with these and other codes or legal requirements related to admission procedures, and to adequately familiarize those working under their supervision with the procedural implications of such codes and requirements.

5. **RECISSIONS:** POLICY 430-2, subject: "Inpatient

Admissions," dated September 11, 1974, as amended and POLICY 430-3, subject: "Status Changes to Inpatients," dated May 7, 1974, are hereby rescinded. All copies of the rescinded policies will be removed from Policy and Procedure manuals and destroyed.

OFFICIAL:

/s/ MELL S. PELOT
Mell S. Pelot
Deputy Superintendent
(Admin.)

APPROVED:

/s/ DONALD G. MILES
Donald G. Miles, Ed.D.
Superintendent

DISTRIBUTION:

B (less 4 and 8); C-3/8;
D; E; F; G-2/4/5; H-2/6

Prepared by:

Task Force on System Coordination

Coordinated with:

Policy and Planning Council;
Northeast Georgia Mental Health Consortium;
Coordinator, Admissions and Evaluation

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR JOHN J. GATES and DOCTOR W. T. SMITH, taken on the 4th day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, S.W., Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

For the Plaintiffs:
GERALD R. TARUTIS, ESQ.
DAVID GOREN, ESQ.
STEVE GRANBERG, ESQ.
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For the Defendants:
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132 Judicial Building
Atlanta, Georgia 30334

[2]

MR. GOREN: The stipulations are all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The signatures of the witnesses were specifically waived by their attorney of record, Dorothy Y. Kirkley, Esq.)

JOHN J. GATES AND W. T. SMITH, HAVING BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

NOTE: (Defendant's Exhibits Numbers One and Two were marked for purposes of identification.)

Q Would you state your full name for the record, please?

A John J. Gates.

Q And where are you employed?

A Central State Hospital.

Q Do you have a Ph.D,?

A Right.

Q In psychology?

A Correct.

Q Would you identify Exhibit One please?

A This is my curriculum vitae.

Q (To DOCTOR W. T. SMITH) Now would you state your name for the record, please?

A W. T. Smith, and I am the Chief Medical Officer at Central State Hospital.

Q And are you a medical doctor?

[3]

A Medical doctor.

Q Would you identify Exhibit Two? Is that your curriculum vitae?

A Yes, ma'am.

Q Now, Doctor Gates, would you state, please, what your job is and what your duties and responsibilities are at the hospital?

A My title is Director of the Regional Mental Health Center at Central State Hospital, which involves a responsibility for coordinating all . . . administrative, personnel resources to effect patient treatment for a roughly two thousand bed psychiatric facility. That includes adult psychiatric patients, alcohol and drug patients, and children and adolescents.

Q All right. Are there components of Central State Hospital for which you do not have administrative responsibility?

A Yes, the components known as a Forensic Services Center, Medical and Surgical Center, Regional Developmental Center, and the . . . . . Rehabilitation Center.

Q But you have a responsibility for . . .

A And the administrative support of it.

Q Do you have responsibility for the treatment services to mentally ill children and adolescents . . .

A I do.

Q . . . is that correct? And what region does Central State Hospital Serve?

A The portion of the hospital that I am in charge of has three divisions. One of these divisions is known as the regional division, which has responsibilities for—services for a twenty-three county area in middle Georgia. A second division, a state-wide division, which is—deals with adult psychiatric [4] patients, continues to have some responsibility for patients all over the State of Georgia.

Q With regard to children and adolescents, particularly, does the Regional Hospital have responsibility just for those twenty-three counties?

A No, the children and adolescents unit has a major mission of providing services for those twenty-three counties, but because of the fact that the Regional Hospital at Rome is not yet—does not have a functioning children and adolescents unit, we continue to receive youngsters from that area.

Q Do you have within your twenty-three county region, now, excluding Rome, community mental health centers?

A We have one comprehensive community health center located in Macon, a mental health clinic located in Dublin, a mental health clinic located in Warner Robins, and out-patient services provided in conjunction with the Baldwin County Health Department in Milledgeville.

Q And would these facilities serve all of the counties within the twenty-three county area?

A Well, each would be responsible for a designated catchment area surrounding those major cities.

Q Which would include more than just the county in which the facility was located?

A Yes.

Q What is the relationship between the hospital and the community mental health program?

A We have—some of our staff, in fact, assigned to various programs in the community. In other cases we have staff who spend part of their time providing services in one or more of [5] the communities, and generally we

work cooperatively with mental health people in all of those communities.

Q Doctor, what is the admission process for people to the Regional Hospital, with particular emphasis on children and adolescents?

A As much as possible we try to have the community people deal with youngsters on the outside. If a child gets to the hospital, then we have an evaluation team during regular working hours who will screen the individual in terms of suitability for admission. In the case of under-aged individuals, frequently there is a question about the possibility of mental retardation, in which case we also try to involve the staff of the mental retardation unit in the determination. If it's determined that a child requires hospitalization, in most cases he's sent directly to the children and adolescent unit, where the staff there then begin a systematic process of evaluation and treatment as prescribed in one of those documents.

Q Let's back up for just a minute. Do the community mental health programs play a role in the admission process?

A To some degree. The Milledgeville area has a child and adolescent coordinator with a small staff, and we're trying to develop more services. She does relate on a rather routine basis to staff and the in-patient unit. The same is true actually, also, for child and adolescent coordinators in the other three major areas. In addition to the identified community mental health people, we have case workers for D.F.C.S., . . . services workers, and a variety of other people who contact staff of the children and adolescent units who come to—help get them involved in the determination of whether [6] hospitalization is indicated.

Q Do you have any idea what percentage of children would have been seen first at the community mental health program and evaluated there before they come to the hospital?

A I really don't. I can say they have something here which indicates that since 1972—we don't have any records on this prior to that time because we were ordered to destroy some of our files, records management people at the state level—this document indicates that during this three year period we've had—we have a record of fifty-two of the youngsters who were screened by staff of the child and adolescent unit. This was done by following direct contact between a variety of people out in the community and the staff—with the staff of the C&A unit.

NOTE: (Defendant's Exhibit Number Three was marked for purposes of identification.)

A I think that particular document addresses itself specifically to the question of whether or not the staff in the unit, the in-patient unit, have any opportunity to participate in out-patient evaluation or pre-admission screening.

Q This that you are referring to is Exhibit Number Three?

A Yes. In addition to that, I might say, that there is undocumented frequent contacts by phone and personal contact between various staff of the C&A unit, and the same multiplicity of people involved in youth services in the community. We now have identified staff in the C&A unit who team travel to Macon, Rome, Warner Robins or Dublin, for example, on a regular basis to work with the staff out there.

[7]

Q Now when a child comes to the Regional Hospital, is he first evaluated at the children and adolescent building?

A No, generally he's not. The child appears in the admissions office. He is usually seen by what we refer to as an admissions evaluator who may be a doctorate level psychologist, social worker or nurse, in conjunction with the admitting office physician. Hopefully, there are relatives, parents who accompany the child. Their effort is to determine whether or not hospitalization is the more appropriate treatment modalum for the kid. After regular working hours, the children are seen by the officer of the day, physician who is on call, and a determining decision of whether to admit or not is made by that person.

Q During the regular working hours when you have the admitting physician on duty, is the C&A unit involved at all in the evaluation conference?

A No.

Q So the decision is first made by the admitting physician, and then the child is admitted to either the child or adolescent unit, is that correct?

A Right.

Q Does an evaluation take place upon admission by either the children or adolescent unit?

A Yes, as you can see in that document I was referring to here is what we refer to as a responsibility action format, on the top here which generally describes what the procedures are that are gone through.

NOTE: (Defendant's Exhibit Number Four was marked for purposes of [8] identification.)

NOTE: (Defendant's Exhibit Number Five was marked for purposes of identification.)

Q Would you identify, please, Exhibits Four and Five?

A By name?

Q Yes.

A Exhibit Four is an example of an admission program, and Exhibit Five is a memorandum from Doctor W. T. Smith to all physicians regarding required examinations on re-admissions of psychiatric patients.

Q Okay. Now that you've identified both, would you just describe the documents?

A Very briefly, when the child gets down to the C&A unit, there is a physical examination and a mental status examination done generally in accordance with the requirements outlined by Doctor Smith in here. In addition, one of the team members, who may be any one of a variety of kinds of personnel, is designated as a big brother or a big sister. Their task is to get to know the child, to spend a certain amount of time with the child every day during the evaluation period, to make entries in the chart as to how the child is doing. In the meantime if a psychological evaluation has been ordered, a social history has been ordered, these are developed and by the seventh day, then, there is a—what is called a team meeting to thoroughly and comprehensively review the status of the child to determine the need for continued hospitalization, for possible alternative treatment modalities, and if hospitalization is indicated, what kind of treatment program should be developed.

[9]

Q During this seven day evaluation period, does the

staff and the units go outside of the records so far to determine whether or not hospitalization . . .

A Yes, there's always an effort to—hopefully when the child is brought in, you take advantage of—by the way, I think earlier I said the C&A staff is not involved. That's not quite accurate. Obviously if there is a parent right there, they're going to try to get hold of that parent to sit there and talk—to get as much information as they possibly can. They'll also try to contact any other people who may have been involved with this child prior to admission to see what information they can gather that would bear upon the disposition of the child.

Q What other sources might they contact?

A Well, you name it. Parents, relatives, schools, D.F.C.S., juvenile courts.

Q Would—this would be done at the initial admitting phase and then perhaps supplemented?

A They'll try to get this information as rapidly as they can. Now the fact of the matter is, of course, that you don't always get it, and the fact of the matter is that sometimes the people don't make the contacts they should make.

Q What efforts are made in your region, Doctor, to treat the family at the same time as the child is being treated?

A We do make efforts. I don't know how to quite characterize it. The fact of the matter is that many of the parents of these children are having difficulties of one kind or another [10] themselves. Some of the children, I don't really know the number of them, I guess it's a large percentage, come from broken homes and so forth, but they

do try as much as they can to get the other—get parents involved in treatment. Now what percentage of the cases this is done, I really don't know.

Q Who would have that knowledge?

A I would imagine the chief social worker might know that better than anybody.

Q And who would that be?

A Carolyn Grant.

NOTE: (Defendant's Exhibits Numbers Six, Seven, Eight, Nine and Ten were marked for purposes of identification.)

Q Doctor, if you would just identify for the record, please, what each of these exhibits is and explain how the information was derived and who did it?

A All right. Exhibit Number Six are applicants under seventeen years of age for voluntary admission who have been screened by what we refer to as our admission evaluation team, the four people I alluded to earlier, during the past roughly eight months, from April 1, 1975, to November 30, 1975. These people work during regular working hours, a forty hour week. This document demonstrates that during this period of time these people have actively participated in the screening of twenty-nine youngsters, nine of whom were not admitted to the hospital, but rather were referred to a variety of other places, community mental health centers, other regional hospitals, psycho-educational programs, and appropriate [11] community resources units or retardation facilities.

Q And where did that information come from?

A This information was put together by one of the members of the admission evaluation team, Don Harris.

Q And Exhibit Seven?

A Exhibit Seven is a summary of applicants for voluntary admission who were subsequently admitted under eighteen years of age from April 1st, '75 to November 30, '75. It shows that we had a total of seventy-one such individuals, and gives the various assignments in the hospital—that is placements, where they were placed in the hospital once they got there.

Q Okay. Who . . .

A This information was also put together by Mr. Don Harris.

Q All right. And number Eight?

A Okay. Exhibit Number Eight is a list of children and adolescents who have been discharged from Central State Hospital since 1969, giving their type commitment, case number, convalescent leave date, discharge date, diagnosis code, disposition and days in hospital. This document reflects that there were a total of seven hundred and thirty-three cases, two hundred and thirty-two of which were court admissions, one hundred and thirty-six of which were medical commitments, and three hundred and sixty-two of which were voluntary admissions.

Q By medical commitments you mean in counties that use the medical procedure for admission?

A Correct. That's right. Of these seven hundred and thirty-three people released from Central State Hospital during this period of time, the document also summarizes the fact that five hundred [12] and three of them were released to parents, fifty-four were released to relatives, forty-one were released to the Department of Family and Childrens Services, thirty-six were released to courts,

nine released to other regional hospitals, twenty-three released to foster homes, and sixty-seven released other, and I think a review of the list itself can indicate what is included in "other".

Q Okay.

A I would like to—of the three hundred and sixty-two, and there may be three hundred and sixty-one, I'm not sure, voluntary admissions—two hundred and sixty-two, is that right?

MR. GRANBERG: Three.

A Three? I believe it's—well, I don't recall. I thought I had those facts in my head but I don't have them, so I won't say anything. What I was trying to say is that the overwhelming percentage of the voluntary admissions were released to their parents or to relatives or legal guardians. But the overwhelming percentage to—directly back to their parents.

Q And number Nine?

A This is a list of children and adolescents who are currently on convalescent leave from Central State Hospital.

Q Okay. Number Ten?

A Number Ten is a list of children and adolescents who were admitted to the children and adolescents unit, and subsequently transferred to other areas of Central State Hospital, and I believe this list goes back to—transfer dates going back to at least 1969. I don't think there were any 1968's in that. [13] Can I refresh my memory by just alluding to that?

Q Yes.

A The patients on that transfer-out list who were voluntary since 1969, we had a total here listed of twenty-three. I think if you count—the source of that is a count—if you count the voluntary patients you'll find twenty-three of them who were treated in the children and adolescent unit and then reached a cut-off point and were transferred to other areas of Central State Hospital, nine of those twenty-three went to geographic units, twelve went to the Yarbrough Rehabilitation Center for specialized training, and two of them went to other areas. Of the nine who went to geographic units, as of December 1st only two are still in the hospital. Of the twelve who went to the Yarbrough Building, only five are still in the hospital as of December 1st.

Q What is the age at which they're transferred to other units?

A Seventeen years right now. When they reach their seventeenth birthday. Of the patients—I think there is thirty-eight patients listed on the convalescent leave list, I think a count will show that twenty-six of those thirty-eight children are . . . convalescent leave in the custody of their parents.

NOTE: (Brief colloquy.)

Q Yeah, this is what I was getting at. I mentioned before that the overwhelming majority of the discharged voluntary patients went to their parents, the number is two hundred and sixty-one out of the total that went back to their parents.

NOTE: (Defendant's Exhibit Number Eleven was marked for purposes of identification.)

Q If you would, identify Exhibit Eleven?

[14]

A Exhibit Eleven is a list which attempts to characterize the variety of music therapy activities provided during intervals for children in the children and adolescents unit. It also shows a memorandum from the director of the C&A unit for—for supervision for walk outs. It has a description of suggested responsibilities for big brothers and big sisters, which is generally followed. There is a behavior check list which is utilized. A memorandum from a variety of members of one of the treatment teams to the unit director saying they are going to adhere to certain guidelines for children and adolescent programs, at least quarterly preparation of a written program, monthly progress notes, written evaluation of each child's problems to be presented in the preliminary staffing, more individualized programs rather than primarily group activities, daily schedules and so on, and much of this is followed. There are, of course, exceptions.

Q In general is that document describing some of the aspects of the children and adolescent program?

A I think it's a fair, not entirely, not perfectly accurate description, but it is a fair description.

Q Does it include all aspects of the program, or just certain ones?

A That plus the earlier exhibit, I think, gives a fairly thorough idea of what goes on.

Q Once a child is admitted to the hospital, Doctor, what kind of periodic reviews are made of his case and the need for continued hospitalization?

A The teams meet at weekly intervals to discuss various cases. How often a particular child comes up for review varies from child to child, and I don't think it

would be accurate to [15] try to characterize a specified time for systematic, periodic review.

Q Would there be an outside limit?

A I would say that the overwhelming majority of the children are discussed at team meetings, their status reviewed, generally no more than at sixty day intervals.

Q Are there ever any reviews by staff members outside of the C&A unit?

A The utilization review committee periodically will try to assess how well the facility, the hospital services, are being used in trying to foster care. I think you've got some documents here which speak to that.

NOTE: (Defendant's Exhibit Number Twelve was marked for purposes of identification.)

NOTE: (Brief colloquy.)

Q Exhibit Number Eleven were different documents discussing the program?

A Yeah.

Q And in the interim there, we found another document which is an example of the case program?

A This is an example of some notes that one of the team members would make in showing the various check list elements, a narrative description, as well as specifying the date on which the child was seen by the individual filling this out, as well as during what time during the day—a half hour for example, minimum of thirty minutes a week.

Q So we're adding this to Exhibit Number Eleven. Now would you identify Exhibit Number Twelve, please?

[16]

A All right, Exhibit Number Twelve is material dealing with utilization review plans and activity.

NOTE: (Brief colloquy.)

A This total Exhibit consists of a memorandum which I sent to Mr. Charles Methvin up here in response to a request from Doctor Skelton, regarding an example of utilization review plan, and there is an attachment here with a utilization review plan of the Regional Mental Health Center of the Central State Hospital. Another part of this Exhibit is a sample of the minutes of the utilization review committee of May 6th, 1975, describing a summary of their review of eleven charts in the children and adolescent unit. And the third section of this is detailed utilization review procedures now being utilized, recently implemented, that have been approved by the Executive Committee of the medical staff, I think, back in September, have been under discussion—a special committee was appointed by me several months before that. I don't recall how long ago. This is a—procedures which list specific criteria for admission which our utilization review coordinator, who is a nurse with a Ph.D. in nursing research—that is her job. This is being used now for patients in our evaluation section, has not yet gotten to the children and adolescent unit, however it is utilized for some of the individuals who wind up in an evaluation area —our seventeen year olds. It has been used during the past—since November 1st for over a hundred cases—review cases, and there is a form here which is utilized by this individual and this material is then presented to the utilization review committee for their discussions . . .

[17]

Q And is this all—this one packet part of one process . . .

A Yes, it is essentially all the same process.

Q And these procedures are in effect right now?

A That's right.

Q And are all cases reviewed at some period?

A No.

Q Are they selected . . .

A Right now—right now we are focusing on our admissions area. This is an area that we need to develop additional strength in, so the utilization review coordinator is spending virtually her full time reviewing cases of people in the evaluation—during the evaluation period. In fact, in most cases—well, within one to five days after admission.

Q Does she also review the child and adolescent admissions?

A No, she's not doing that at the present time. She's only one person and we have a fairly high admission rate. The—as I indicated, some seventeen year olds—people between seventeen and eighteen are placed in this area, so some charts of these individuals have been reviewed. I have no idea what the number has been, but these particular procedures have not yet found their way down to the children and adolescent unit. We have only one utilization review coordinator, and that is on the drawing board at the present time. I might say that the utilization review plan describes both admission criteria review as well as extended stay review, and some extended stay review

has been done. The committee is thinking—and has been doing it to some degree at sixty day intervals.

Q Does that apply to children and adolescents?

[18]

A It will apply to children and adolescents.

Q It has not yet?

A No. Now the utilization review committee, prior to the development of these more recent procedures, as indicated in one of the attachments there, did specifically focus on the C&A in May of this year.

NOTE: (Defendant's Exhibit Number Thirteen was marked for purposes of identification.)

Q Okay, Doctor Gates, would you please identify Exhibit Number Thirteen?

A Exhibit Number Thirteen is a list of individuals under the age of eighteen emotionally disturbed and presently at Central State Hospital—in Central State Hospital as of December 1st, 1975 as well as samples of admission material on each of those sixty-three people.

Q What is included for each person?

A Okay. Now this will vary to some degree, but generally there is an admission summary, physician's admission note, a history of mental illness, social history, psychiatric examination, and any legal documents that may have accompanied those patients from the . . . was relevant.

Q Okay, Doctor, my last question, one of the contentions in this case is that judicial proceedings are necessary before admission of the child to the hospital. In your opinion as superintendent, would judicial proceedings be

necessary in every case prior to the admission of a child to the hosital?

A No, I don't—I don't think that such proceedings are indicated in every case. In fact, in my review in preparation, frankly, [19] for this deposition, the evidence that we have seems to me to clearly indicate that in the overwhelming majority of cases, there has been considerable prior involvement with a host of agencies and private providers with most of our children, which is to say that if hospitalization has not been the last resort with these youngsters, it certainly has been close to it. In my reading a sample of the materials in Attachment Twelve, and I think anyone reading it would confirm this impression, one can see a history of involvement with the mental health centers, special education programs, the Departments of Family and Children Services, the Juvenile Courts, children's homes, detention homes, private providers such as psychologists and psychiatrists, until apparently the child got to the point where all of these other resources had been pretty much exhausted, and it was felt that the only remaining option was hospitalization. Based upon the evidence which we've already presented regarding the disposition of the bulk of the patients whose parents volunteer them to the hospital, it seems clear to me that these people are concerned, that they have an on-going continuing interest in their child, that they are the ones who have finally come to the point where they feel that the best thing that they can do is try to get the child in a hospital. I say this partly because, as this can usually be seen, the majority of the children who have been released from the hospital have gone directly back to their parents.

Q Are you aware of any problem because of the reluctance of parents to take their children back home when your staff recommends it?

[20]

A I think certainly there have been cases where parents have been reluctant to take their children back home. If you have a rather hefty adolescent who is threatening to elderly parents or grandparents or youngsters in the home, who has a history of being ungovernable, there is reluctance, certainly, on the part of some of these parents to have their children come back.

Q Do you have any indication of the percentage of cases in which this occurs?

A I really do not.

Q Okay. That's all the questions I have.

EXAMINATION BY MR. GOREN:

Q Doctor Gates, you went into rather great detail in your testimony about the various sources that are contacted prior to the admission of—or upon the admission of someone to the hospital, is that right?

A Yes.

Q Why were you emphasizing it?

A I think to try to convey the effort on the part of the staff to have as much information available to them as they can about the child.

Q Why is that important?

A Obviously that the more you're aware of the history and the current environment that may effect the child's psycholcgical state, the more you can bring to bear the resources at your disposal to effect programs which are best suited to that kid.

Q And are there many sources that are contacted in trying to find this information?

A I frankly cannot quantify that, and do not know exactly what [21] is being meant by "many". I do know that the staff down there is frequently on the phone and writes many letters requesting information.

Q How is this—do you know how this information is utilized in arriving at a decision to admit someone?

A I think the various members of a team will sit at a team meeting. Typically, it's my understanding, that one of the members of the team will be the person designated to, quote, "present the case for the child." And the various members of the team then contribute what they know about the child in order to try to figure out what's the best way to go about providing a treatment setting for them.

Q And the gathering of information on the child is very important in doing that?

A I believe it is.

Q So you would like to be assured that you have all the information available on a particular child prior to a decision to admit in non-emergency situations?

A I think I would like to be assured that we have expended every reasonable effort to obtain as much information as we can at the time that a decision of one kind or another has to be made.

Q Is it possible that because for one reason or another all the information cannot be obtained?

A Certainly it's possible.

Q Okay, is it possible that because that information

wasn't able to be obtained that it could have some effect on the decision to admit a child?

A That is possible.

[22]

Q Okay. You spoke a bit before about some parents who you felt were reluctant to take their children back into their homes, that for one reason or another they do not desire to have these children back, is that correct?

A Correct.

Q And I believe you also spoke about the concern of the hospital to try to get the family involved in a child's therapy, is that right?

A Correct.

Q Why is that? Why is that necessary?

A The child, more than a developed adult, must return to an environment wherein much of his life, much of his behavior, is directly affected by adults who have responsibility for him. He's in a developmental period, being strongly affected by his familial and social situation. It does not make sense to try to provide an environment such as one in a hospital, which does not try to cope with the reality that the child must return to.

Q What effect do family interactions have on a particular condition of the child?

A That's an awfully general question, and I would think that you could bring to bear volumes of literature in child psychiatry and child psychology to answer that in one of a million different ways.

Q More specifically, would you say that the—it is very important to understand what the mental condition of the child is to be able to understand how parents operate and what their interactions are with their child?

A I'm not sure I understand that question. Would you rephrase [23] it, please?

A Okay. Is it important to understand how the parents interact among themselves and with their child in understanding the mental condition of the child?

A I think that that information certainly contributes to some degree, to a more complete understanding of the child's psychological state.

Q In your experience, have you ever found situations where the parents themselves required psychiatric treatment?

A Yes.

Q And have you ever experienced situations where parents, because of their own psychiatric difficulties often appeared to be at odds with their children in the sense that they would blame their children for certain acts that occurred within the family setting?

A I would say that I've had personal familiarity with certain cases, not at Central State Hospital, but elsewhere, where the psychological state of the parents did not appear to be, but definitely did have some bearing upon what they might or might not attribute to the child in terms of familial problems.

Q Okay. Now when you're out gathering information to make a decision on whether or not to admit a child to the hospital whose application is being sought by his parents, who would the primary source of information about that child be?

A I would expect, in many cases, that the parents would be the major sources, primary sources, of information. However, I think that in discussing the situation

with the parents, an alert interviewer, an alert clinician would make every effort, on the [24] basis of the information presented to him by the parents, to explore and seek the permission of others to explore other sources of information. For example, the schools, private physicians, whatever other providers may have been involved with the child. Relatives.

Q But you would think the parents would be the primary source of information?

A Yes.

Q Okay. In a setting where parents, then, may have psychiatric problems, may in some instances, as you said, blame the child for certain problems within the family. Would you think, then, it's possible that parents may misinterpret or mispresent (sic) or distort facts when they're being asked to describe the behavior of their child?

A I think it's possible for anybody to distort or misrepresent the facts in any situation in which they are personally involved—or even not personally involved. One would hope that the clinician involved in such an activity would have sufficient expertise to be able to discriminate the distortion from the reality.

Q Is this often done quickly and easily?

A What do you mean by "quickly and easily," now?

Q When you have a situation in which there are complex interactions between the family and the child which are necessary to understand before a decision can be made to admit a child, is it often difficult to discover these facts that you're going to need before you can make a decision?

A I think it's sometimes quite difficult; sometimes people are transparent.

[25]

Q Okay. In cases where it's difficult to obtain the facts, and it's not an emergency situation, would it be possible that your staff would take a couple of days to try to gather all the factual information available that they could before they would make a decision on admitting a child?

A I would imagine—for example on a list of fifty-two patients who have been screened by the staff down there that there have been instances where the evaluation process had taken several days.

Q Okay. And during this several day period, where would this child be during this information gathering?

A I believe, I don't know this for a fact, because I was not directly involved with it, but I believe on the basis of the information available to me that in some of the cases, the children simply remained at home.

Q Okay. Do you think it's possible, because of the conflicts, again, that parents might not readily reveal all the information which would be important in making a decision about a child?

A That's certainly possible.

Q Would you think it would be helpful if procedures could be established so that there would be an increased chance of finding out information from parents that they would not readily reveal?

A I think the way I would answer that is to say that anything we can do to ensure the validity and comprehensiveness of the information that we have, that would contribute to a decision, would be helpful.

Q Okay. In describing—or in answering Ms. Kirkley's question [26] about is a hearing necessary in every case,

you said, "No, not in every case," that in most cases you felt there is considerable effort made to try other remedies, and hospitalization is probably close to the last resort, is that right?

A What I said was I based upon my review of samples of the materials presented there, my impression was that in many of those cases there is documentation of the participation and involvement of a host of providers and agencies prior to the hospitalization of the child.

Q Okay. But in some of those cases that wasn't evident?

A I can think of one that struck me as—one of the samples in there that I read, and I did not read them all—one that struck me that had not had a whole lot of participation by other agencies. If I recall it, the child had had a history of minor altercations with police officials, had finally, I believe, committed some kind of a more major offense, and in the rural community, the sheriff was familiar with the child and the family, and in lieu of pressing charges, the parents agreed to seek psychiatric help for the child. And I think in that case there may have been some documentation of the child having had difficulties in school, but I couldn't—it kind of stood out because it—I didn't see any other evidence of mental health clinic people or private psychiatrists or psychologists or something.

Q In this kind of situation where the child is admitted as a voluntary patient, presently there are no proceedings which a child is required to go through prior to admission, is that correct?

A No procedural—prior to the time the child gets to the hospital?

[27]

Q Yes.

A No.

Q Okay. Now is it your feeling that in cases where we're concerned about whether or not alternatives are exhausted or whether or not all the facts could be obtained to make an appropriate decision on a child concerning admission, that in those situations is it really harmful to have a hearing, let's say before some arbitrator, who would be able to check out facts that perhaps parents couldn't reveal, for instance if the parents had a history of child abuse, that may be something that they might not readily reveal, and the court could have access to that. In your opinion would that be harmful to a child?

A Could you describe for me a little bit more about how you would see such a proceeding before I answer that question, because I'm not sure that perhaps the nature of the proceedings might have . . .

Q Okay. In a proceeding where the objective of the proceeding—and it's obviously a flexible thing at this point—that the objective of the proceeding would be to discover information, all information available about a child, and to exhaust all alternatives—investigate all alternatives prior to admission in a non-emergency case. That would be the function of the hearing. Do you think that would be harmful to a child?

A I'm not sure that that in itself would be harmful. I would like to think that if a parent brings a child to a community mental health center, for example, that the staff there [28] substantially do conduct a professional hearing. And one would like to assume that—with a certain degree of expertise. As I said earlier, I think any

procedure that would contribute to the thoroughness of the information would be helpful.

Q You said, "You would think," and, "You assume." Do you know that proceedings go on in community health centers for that?

A It's my understanding that when a child is brought to a community mental health center, that the child is studied, the parents are interviewed, the case workers, social workers, try to obtain as much information from school authorities and so forth and so on.

Q But that's not a formal hearing—proceeding?

A No, that's why I said substantially.

Q Okay. Doctor Gates, when you were talking about admission procedures at Central State, I believe you said that all children, and that is persons younger than eighteen years of age who were voluntarily admitted by their parents, first go to the admission center in the Howell Building, is that right?

A No, no, no, no.

Q Where do they go first?

A The children and adolescent unit does not accept youngsters below the age of seventeen. (sic)

Q Okay.

A Generally people who are between and—who are over seventeen would go to the evaluation ward. In some cases, of course, they go directly to the geographic unit or if certain other special conditions are in effect, they may go someplace else at Central State Hospital. The youngsters under seventeen, by and large [29] go directly to the C&A.

Q Their first interview is not in the admissions building?

A Oh, no, I'm sorry. When these youngsters come to the admissions office during the regular work week, they are talked to, screened by one or more members of the admission evaluation team in the admission office.

Q Are there written procedures describing what is to be done at that first screening?

A No.

Q Do you know what, in fact, actually happens at that first screening?

A Ms. Scott, Mr. Harris, Ms. Shirley, whoever is involved, will wait until a clerk has obtained certain kinds of . . . largely administrative information, will then sit down with the—whoever accompanies the child, to try to get some idea—in fact, conducts an interview. They have used a variety of check lists, and narrative descriptions. Based upon that, if there is some question on the basis of their observations and talks with the children, say intellectual functioning of the child, they try to get a psychology technician to come down and do a very brief mental exam. After this, the admission evaluator will get with the admitting office physician and, in effect, present some recommendation as to what is felt to be more suitable. One of the exhibits there shows that during the last eight months nine of the twenty-nine people who were screened in this manner were referred to what the—the admitting office physician is the one who makes the decision, based on personal observation of the child, as well as the [30] recommendation of one of the members of the admission evaluation team. When someone, and this, of course, is true not just for children, but for anyone else,

when someone is refused admission, there is always an effort, and a largely successful effort, to refer the person to some other facility, a community mental health center, or . . .

Q When the child is accepted in this facility, do the —when the screening physician does make the decision to admit . . .

A Then the child is sent directly to the children and adolescent unit.

Q Suppose that child is diagnosed as mentally retarded, after—you said a psychologist may come down if there is some indication and do a quick test on the child, what happens to the child?

A When it seems indicated that the child is mentally retarded, the staff of the community resources unit is contacted to help assist with this physician. Since there is a very strong attempt on the part of the community resources unit, the mental health facility generally, to admit only after a pre-admission evaluation, they, in the clear cases of mental retardation, try to make arrangements for the child to be dealt with otherwise.

Q Suppose that child or adolescent is from the Rome catchment area?

A Then the mentally retarded individual will typically wind up in the children and adolescent unit, if admission is clearly indicated, until such time as he can be relocated in a Rome mental facility. In some cases the individual may be sent to DAC.

[31]

Q What is DAC?

A The evaluation ward.

Q That is where adults are evaluated?

A True.

Q Does the children and adolescent unit accept persons that are diagnosed as retarded?

A The fact is that they do despite the fact that they are not very happy about it.

Q And what happens with those persons who are sent to DAC, what happens to them?

A The majority of those, if they have to remain in the hospital, will wind up down in the children and adolescent until they can be relocated elsewhere. Some of them are also sent to some of the geographic units.

Q And those geographic units are adult wards?

A They are.

Q Okay. Now after a child is sent to the C&A—the children and adolescent unit, is that where you started describing the responsibility action format?

A Yes.

Q Okay. When was that procedure first implemented?

A Roughly November of '74.

Q That's when this was first distributed?

A That's right.

Q Now, you were also describing at one point, and I believe it was in reference to Exhibit Eight, concerning the history of the children who are admitted as voluntary patients, that two hundred and sixty-one out of three hundred and sixty-two of [32] those children were returned back to their parents . . .

A Uh-huh. (Affirmative.)

Q . . . is that right?

A (Nods in the affirmative.)

Q Which percent of those cases, do you know, were subsequently rehospitalized?

A I don't know.

Q Okay. You also testified, I believe, that at the age of seventeen that children who had been on the adolescent ward or adolescent unit, were then transferred to adult wards, is that correct?

A That's right. I believe there's an exhibit there that describes twenty-three such individuals.

Q Okay. Isn't there also a policy in the C&A unit that —let's say, for instance, a person who is admitted there was pregnant or has a child, that they would be transferred to an adult ward?

A There has been such a policy.

Q Okay. And that is irregardless of the age of a person?

A The youngest that I'm aware of was thirteen.

Q And that person was placed on an adult ward?

A I know the patient was placed in the Jones Building for some period of time, and I think that person was also placed for some period on an adult ward.

Q Okay. Is that policy still in existence?

A Yes.

Q Now, you were also discussing—excuse me. Is there a certain [33] standardized manual that is referred to in diagnosing children or adolescents upon their admission?

Is there a manual that's used to place a child in a particular . . .

A The Diagnostic and Statistical Manual.

Q Number?

A Two.

Q Okay. Do you know which percentage of the children admitted—volunteer children by their parents, who were admitted in the particular categories listed in the Diagnostic and Statistical Manual Number Two?

A Yes, I do. Of the three hundred and sixty-one or two voluntary patients listed on the Exhibit Number—whatever it is . . .

Q Exhibit Eight?

A Exhibit Eight, the count there revealed that fifty-three had a diagnosis of mental retardation, fourteen diagnosed as a organic brain syndrome of one kind or another, forty-two were diagnosed as a psychoses not attributed to physical conditions listed previously, twenty-five a diagnosis of neurosis of one kind or another, twenty-five a diagnosis of personality disorders and certain other non-psychotic mental disorders, three, a diagnosis of psycho-physiologic disorders, zero had a diagnosis of special symptoms, one hundred and thirty-two had a diagnosis of transient situational disturbances, sixty-one had a diagnosis of behavior disorders of childhood and adolescence, ten—no four had a diagnosis of conditions without manifest psychiatric disorder and non-specific conditions, and two had a label of non-diagnostic. . . .

[34]

Q Okay. You said there was a hundred and thirty-two transient situational disturbances?

A Correct.

Q How is that defined?

A This is a class of disturbances encompassing adjustment reactions of childhood, adolescence, young adult life and later adult life.

Q And it seems, basing the figures that you gave us, that those are by far the majority of the categories?

A They account roughly for one-third.

Q One-third. Are there more diagnosed in that category than any other?

A Yes.

Q And now—what is the nature of that kind of diagnosis? Is that a severe impairment, is it psychosis, could you describe that, please?

A I think it's fair to say that it is a diagnostic category which is used to describe a very wide variety of deviant behaviors in children, which behaviors are frequently felt to be a function of the child's social situation, the environmental stresses to which he is exposed, coupled with whatever developmental events may have occurred.

Q Okay. Is that considered a—are those considered psychotic disorders?

A No.

Q How severely disabling would those disorders be?

A I think that the only—one cannot answer such a question. There is an enormous variation.

[35]

Q So it could run from mild to severe?

A Yes.

Q Okay. Concerning the periodic reviews that you were describing, I believe you said the treatment teams meet weekly to discuss various cases?

A That's my understanding, that's right.

Q Not every case is discussed . . .

A No, no, no. Definitely, I did not mean to convey that impression.

Q How are these—what are these, random reviews?

A I'm not familiar with the procedures by which they schedule . . . patients.

Q Do you know how these reviews are conducted, what they consist of?

A It is my understanding that there is a discussion by the primary therapist and the other members of the team who are involved with the child, his current status in comparison programs with . . . his status since an earlier review, a provision of any additional information that may have been obtained regarding where the parents are, the social situation, the family life to which he eventually might be returning, any additional progress with respect to financial, legal, whatever matters that may have effected the child's hospitalization in the first place.

Q Is there a member on that committee who does have legal training?

A No, there isn't. No one who has clearly identified legal training, although it's hard for professional people to function [36] in a psychiatric hospital these days without some awareness of legal matters. (Laughter.)

Q Okay. Do you know how these team meetings are conducted, who leads them, how decisions . . .

A I think that's varies. I think that varies. I do not typically attend such meetings.

Q You also discussed utilization review committees?

A Yes.

Q That's in Exhibit Twelve. Could you just briefly describe how those are conducted and who participates in them?

A I would really prefer not to comment on that myself since I do not participate in utilization reviews. Doctor Smith and other members of the medical staff as well as certain other professionals routinely do.

Q I believe you also said the utilization review committee also, as the periodic that you previously described that were done every week, are done on random cases, is that right?

NOTE: #947

A I think it's fair to say that that has traditionally been the case.

Q I think you also said that one review was done in May of this year, of the C&A unit?

A That's true. There's an attachment to the exhibit.

Q Do you know why that was done?

A No. I would just assume that the committee felt it was timely and opportune to conduct such a review. The committee—I think I can say that the committee has moved from unit to unit, and those minutes, for example, point out that the next meeting would be held in Veterans.

[37]

Q Okay. And I believe you also said that the policy does not yet apply to the childrens unit specifically, that is that they do not do periodically . . .

A No, I think you misunderstood me.

Q Okay.

A The plan, that mode of operation for utilization review, does apply as is evidenced in the minutes of the May 6th meeting. What I was saying is that we have not yet gotten to the children and adolescent unit with our more recently developed, explicit criteria, that a utilization review coordinator utilizes.

Q Okay. Now, is there any periodic review, or any review that's done every so often in a specified time which would review the case of every child within the C&A unit?

A As I said earlier, the staff in the unit at their regularly scheduled meetings, by virtue of the various progress notes that they make and so on, does conduct in a sense, on a rather routine basis, periodic review of various cases. Now if you're asking me is there any directive which says that every case will be reviewed every thirty or sixty days, I would have to answer no.

Q Okay. In the last year do you know how often the utilization review committee has reviewed random cases in the C&A unit?

A I do not know.

Q Okay. Doctor Gates, what would be the effect, do you think, if at these reviews, when they are conducted, that the information that you say is gathered, the study of the present mental status and past mental status of a

patient, if that information were submitted to, say, a psychiatrist outside of the unit, who is [38] independent of the hospital, say, for his review, do you think that would be unduly burdensome on the review process?

A No. As a matter of fact, the utilization review plan, which is part of the Exhibit here, specifically mentioned that a physician or psychiatrist should not participate in the utilization review in cases for which he is directly responsible. The composition of the utilization review committee is a rather broad one, so it is possible to conduct the utilization review in that fasion.

Q Okay, but . . .

A In effect you wind up with outside professionals looking in on the work of others.

Q And you believe that to be beneficial?

A Yes.

Q Why?

A I think any time any of us can get feedback and evaluation from our peers, it can only serve to improve our performance.

Q Okay.

A I would assume that the same would be true of attorneys as well as psychologists and psychiatrists.

Q Is it also discussed at these reviews, alternatives to hospitalization? Whether or not they would be appropriate and what alternatives are available?

A Yes, I believe—I believe that if you'll read the sample of the utilization review committee report, you will see a question is raised there on that one particular case with respect to alternatives.

Q Okay. What effect do you think it would haveon this review [39] process if the findings of the review and the facts of the review were submitted to an independent arbitrator, someone who is independent of the system, to review and search out alternatives and to compile the facts and make a review based on what has been submitted to him?

A Le me be sure I understand what you are saying. What effect would it have if an independent arbiter were to do this kind of utilization review?

Q Yes.

A I don't know. What possible kinds of effects are you . . .

Q You said, for instance, that if someone who wasn't involved in the treatment team, if they could give their opinion on what needed to be done, that could be really helpful. Okay, I'm just taking that a step further. It it was someone who was not a person who would review it like that, but someone who was outside of the system who would examine all of the information and search out alternatives, if that also would be helpful in the same sense of submitting the information to someone outside of the treatment team for their opinion?

A It might and it might not. I think—one would like to think that in such a utilization process, what you're doing is bringing to bear the judgment and experience of peers—professional peers, who do not have a particular interest in a case one way or another, and who have a capability within the framework of not being liable, or not being punitive, to give honest feedback, unless one assumes that such reviewers, who would be members of the staff located elsewhere in the facility—or unless one

assumes that the staff themselves have no interest in [40] seeking alternatives.

Q I'm not talking about those kind of assumptions, because I assume that everyone does really do their best to try to find it, but unfortunately—let's talk about this. Do you feel like your staff has large case load problems?

A Do I feel like that our staff is worked to the limit?

Q Yes.

A Yes.

Q Okay. And because of that, because you feel that they're worked to the limit, is it possible that because of that work load they may not be able to check out all the alternatives?

A That is certainly possible.

Q And if there was someone else outside who had the time and who had the experience and who had the where-withal to check those out, wouldn't that be beneficial?

A I'd like to think that our community liaison people do precisely that, and rather than a person be completely outside of the system, I'd rather have them on the staff.

Q But is that, in fact, what happens? I mean do those outside people participate in these reviews?

A They sure do. Our staff is routinely on the phone, or writing letters . . .

Q No, but I mean are they there at these periodic meetings?

A Generally not.

Q Okay. How would you feel if, at these reviews, the child or the adolescent were represented by an advocate,

and not an advocate who would disrupt the proceedings, but someone who would be there solely to present the interests of the child or [41] the adolescent, someone to explore all of the considerations in his behalf, to add his input to the review process?

A The only real way in which I would tend to think that would be beneficial is if one made the assumption that neither the parents or legal guardians or the staff had the same kind of interest.

Q As far as . . .

A I would like to think of our staff as being the advocates for patients.

Q Sure. Is that always the case? I mean, you've described . . .

A I'm sure there are exceptions.

Q Okay. Doctor, now I'd like to ask you some questions concerned about the staff—the staff in particular at Central State. Do you know which percentage of—well, let me ask you first, how many physicians are there at your facility?

A There are roughly a hundred physicians at Central State Hospital.

Q Do you know which percentage of those physicians are board certified psychiatrists, or how many are board certified psychiatrists?

A Three out of a hundred.

Q Do you know which percentage or how many of those physicians are board eligible psychiatrists?

A Approximately twenty-two.

Q Do you know how many or what percentage of those physicians are licensed M.D.'s?

A All are.

Q Okay. I mean licensed M.D.'s as opposed to being board certified or board eligible psychiatrists.

[42]

A Oh. Well, several of the physicians that I'm—I have very little contact with are members of other specialties, so I really can't comment on that.

Q Do you know which percentage or how many physicians at your facility are only licensed to practice in state institutions?

A I do not have the number at my fingertips, but we do have several in that category.

Q Okay. Are there any board certified or board eligible child psychitrists at . . .

A We have one board certified child psychiatrist.

Q And where does that person work?

A In the Dublin geographic unit.

Q Is that the children and adolescents ward?

A No.

Q That's an adult ward?

A It is.

Q Does that child psychiatrist have any cases from your children and adolescent unit?

A He has been asked to consult with certain cases, but he does not as a matter of routine work in the children and adolescent unit. I might mention that this man is

relatively new in the facility, and is working in an area now where the previous psychiatrist died.

Q Wasn't he assigned to that unit two days before that doctor died?

A He was, and the intent was to rotate this particular man through all of our regional division units including the children and adolescent unit.

[43]

Q Isn't that—is there also another doctor at the facility who is in training for certification as a child psychiatrist?

A No, he has passed part of the examination for certification in child psychiatry and is studying to take the remainder of that examination.

Q Where does he work?

A He works in the Metro-Atlanta adult unit.

Q Are there any foreign born or foreign trained physicians at your facility?

A Yes, there are.

Q Do you have any idea what percentage or how many there are?

A The number of foreign medical graduates is large. I don't know what the number is. It's over fifty percent.

Q And do any of these physicians have any difficulty with the English language?

A Some of them do.

Q Okay. Do any of these physicians participate in the admissions process?

A Yes.

Q Do any of these physicians participate specifically in the admission process for children and adolescents?

A Yes.

Q In your opinion is it important to be able to fluently understand the language of the child or adolescent that you're diagnosing in order to arrive at a valid diagnosis?

A It's certainly important to be able to communicate —with not only the child, but certainly also the parents of the child.

Q Doctor Gates, are you familiar with the report of the Study [44] Commission on Mental Health Services for Children and Youth published on November 9th, 1973?

A Yes, I am somewhat familiar with it.

Q Okay. Before we go into that a little more, could you describe how the units for children and adolescents are set up at your facility? Is there one facility . . .

A There is a separate building for children with a capacity of roughly forty beds. There are two wards in the . . . Building, one for male adolescents and one for female adolescents.

Q And as to that adolescent unit, this report arrived at a conclusion and recommendation based on that facility, and I guess you agree with that conclusion?

A Would you refresh my memory, please?

Q Yes. The conclusion said, "Plans should begin now for closing the eighty bed adolescent unit. It is a physical facility completely unacceptable for therapeutic rehabilitation of young people."

A I generally agree with the concept that it is not the most conducive physical facility. We are, in fact, presently making plans to move adolescents from that area. Such plans, I might add, that have been under active discussion for some period of time.

Q There is also another recommendation in that it's —and I'd like to ask you if you agree with this, "That it is essential that the new regional hospitals begin children and youth services as soon as possible, and children and youth at Central State and geographic areas . . . hospital services to be transferred."

[45]

A Basically yes, and I think it's fair to say that that has certainly been the effort of our staff.

Q But I believe you did describe that children from the Rome area are still residing at Central State?

A That's correct.

MR. GOREN: I would like to note for the record that Doctor Smith has stated that the utilization review committee has reviewed random cases in the child and adolescent unit once in the past year.

EXAMINATION BY MS. KIRKLEY:

Q When Mr. Goren was asking you questions, he asked you if there were some foreign born or trained doctors who had difficulty with the English language and you said that there were. Are there any such doctors who have difficulties with the English language who work on the children and adolescent unit?

A There are two native Spanish speaking physicians on that unit. I personally have no difficulty understanding them. My observation is that they are able to generate

good rapport and communication with the children and adolescents.

Q That's all I have.

EXAMINATION BY MR. GOREN:

Q Did you notice that other people might have difficulty understanding them?

A Yes, I would think it fair to say that some other people might.

Q And do you think it's possible that they might have some difficulty in communicating with other people?

A I'm sure that's the case on occasion.

[46]

Q And who are those doctors?

A Doctor Zapatero and Doctor Bejarno.

END OF DEPOSITION

* * * * *

[1]

ATTACHMENT
EXAMPLE of
Admission Program
In Responsibility-
Action Format

I. PRELIMINARY SCREENING: Prior to consideration for admission, the referral agency shall contact the staff of the children's building concerning the preliminary screening procedure. No child will be admitted to the children's unit without first receiving or having had a recent psychological evaluation including the WISC, Bender and one projective test (preferably Blacky series or sentence completion test). Historical and background (family, medical and social) data must also be provided whether through family interview or agency records. The staff in consultation with the referring source will determine exhaustion of community resources; if hospitalization is recommended, an explanation of the treatment program and tour of the building will be provided to acquaint the source with the physical treatment setting. It shall be imperative that a contracted agreement defining the roles and responsibilities of both parties be drawn up and signed. (Copy of this contract is attached to this document.)

Due to the requirement for a preliminary screening, no child shall be admitted after 5:00 p.m., or on weekends or holidays.

II: ADMISSION TO THE WARD

PURPOSE: To admit the patient to C & A Unit in a routine manner which will achieve the following objectives:

Gates Defendant's Exhibit Number Four
JMW 12/4/75

[2]

1) Involve the patient immediately in therapeutic relationship and routines with Unit staff.

2) Assure prompt and orderly initiation of all admission procedures.

3) Provide for the planned collection of information necessary for beginning assessment and treatment of the patient's situations.

4) Assure prompt involvement of community and family resources in diagnosis and treatment of the patient's situation.

[2]

III. PARTICIPATING PERSONNEL: Unit Receptionist, Admission Ward R.N., Physician, Admission Ward Charge Attendants, staff persons assigned to interview the patient's family, Admitting Attendant and psychologist (see above).

RESPONSIBILITY	ACTION
Unit Receptionist	1) Courteously seat patient and escort to appropriate area while awaiting admission ward personnel
	2) Notify receiving ward of patient to be admitted.
R.N. (Charge Attendant in R.N.'s absence)	1) Assign Admitting Attendant
Admitting Attendant	1) Meet patient and family in lobby and introduce self in friendly manner.

	2) Take patient's luggage and escort him to ward receiving area, explaining the immediately impending events. 3) If there are relatives, escort them to visitor's room, and inform R.N. (or Charge Attendant).
R.N. (Charge Attendant in R.N.'s absence)	1) Inform appropriate physician of patient's arrival. 2) Assign Big Brother or Sister for each shift. 3) Immediately upon coming on duty, check admission book for emergency admission patients admitted since 5:00 p.m. of the last working day, review patient's condition, and inform appropriate physician.
Admitting Attendant	1) Obtain temperature, blood pressure, height and weight, give admission bath and complete clothes list, money sheet, and nurses admission assessment.
Physician	1) See patient as soon as possible to conduct appropriate preliminary examinations, prescribe medication as indicated, order laboratory studies, and write admission note (if not done in Powell Building). (If patient was seen in Powell Building, review and prescribe medication, if necessary; order supportive lab work and additional examinations.)

Psychologist	1) Determine needs and course of treatment for the patient in conjunction with Big Brother and Sister. 2) Inform attendant staff of any specific restrictions or privileges the child might require (in conjunction with Big Brother and Big Sisters). 3) Implement course of therapy with attendant and nursing staff.
Admitting Attendant	1) Orient patient to physical ward structure—dining and bathing facilities, sleeping areas, dayrooms, etc. 2) Stress supportive reassurance to patient, alerting him to routine events of next few days—lab work, Preliminary Evaluation Meeting, etc. 3) Give patient prepared Orientation Material (see attached), explain basic ward structure, rules and regulations. 4) Discuss briefly Big Brother or Sisters role while reminding patient he will meet them tomorrow. 5) Introduce patient to ward staff and a few appropriate patients. 6) Leave patient with other patients, or in his room. 7) Complete Kardex Card, Nurses Admission Notes, and Notification of Admission. 8) Complete routine lab work slips and place in designated place for R.N.

[4]

Admission to Ward

INITIAL EVALUATION MEETING

PURPOSE: The Preliminary Evaluation Meeting is designed, as is the entire admission process, to utilize the limited information available, including staff observations, to activate all appropriate Unit resources as quickly as possible on the patient's behalf. Objectives of the Preliminary Evaluation Meeting are:

1) To provide an early formal review of the patient by key members of the treatment team. The review will be accomplished on the (7) seventh day following admission.

2) To identify, prescribe and immediately involve the patient with the treatment resources relevant to his situation.

3) To enhance the patient's adjustment to the treatment situation by providing greater familiarity with the members of the evaluation team, and with the activities planned for him during the evaluation period.

4) To arrange for the orderly gathering of information essential to treatment planning and/or disposition.

5) To identify, prepare for, and schedule necessary Forensic Staffings.

PARTICIPATING PERSONNEL: Physician, R.N., 7-3 Charge Attendant, Primary Therapist, and Team Leader. Big Brother & Sister, Psychologist, Music Therapist, Recreation Therapist, and School Representative.

Admission to Ward

RESPONSIBILITY	ACTION
Team (R.N., Charge Attendant, Big Brother or Sister (if any on day shift), Physician Team Leader).	1) See all new patients in the first working day following admission allowing ten to fifteen minutes to each patient for introduction to the Preliminary Evaluation team members, initial evaluation assignment to beginning therapeutic activities, and specifications of additional information required for further planning. 2) On patients with Court Orders, determine additional information required for staffing and set deadlines for this to be obtained.
Physician	1) Write necessary orders.
R.N.	1) Remind team members of meeting.
[5]	
R.N. or delegate	1) Bring charts to meeting
Big Brother or Sister	1) Provide any preliminary supplementary information concerning ward behavior.
Team Leader	1) Familiarize himself with historical date. 2) Conduct meeting. 3) Complete Preliminary Evaluation Form on each patient following recommendations of team. (See attached) 4) Consult with physician regarding the need for Forensic Staffing of each Court Order, set date for staffing, notify Unit

Director's Secretary and inform attending physician at Disposition Meeting.

5) Assume responsibility for seeing that all activities assigned on the patient's behalf are transmitted appropriately and performed.
6) The Team Leader may delegate portions of (4) above to R.N. or Charge Attendant.

[6]

BIG BROTHER OR BIG SISTER DUTIES DURING EVALUATION PERIOD

PURPOSE: To routinely establish a structure for each patient through which the ward's primary therapeutic objectives are obtained. These objectives are:

1) To assure that each patient has one staff member who is primarily responsible for his general well-being and basic progress on the ward.
2) To provide each patient with a consistent, frequent, regularly scheduled therapeutic relationship with at least one ward staff member.
3) To insure that at least one ward staff member becomes sufficiently familiar with each patient to provide reasonably accurate information regarding the patient's background, his present condition and his interaction with the hospital environment.
4) To insure that a specifically designated individual is responsible for communicating information from the patient to the treatment team, and from the team to the patient.

PARTICIPATING PERSONNEL: Primary Therapist, R.N., and Team Leader

RESPONSIBILITY	ACTION
Big Brother and (B.B.) Big Sister (B.S.)	1) Within one-half hour after reporting for duty each day, check B.B. and B.S. assignment for patients admitted the previous day. 2) If a new patient has been assigned immediately find patient and spend 10-15 minutes getting acquainted. 3) The B.B. or B.S. from both the 7-3 and 3-11 shifts will attend the evaluation sessions (at 2:00 p.m.) for each of their children each day. 4) Spend at least 45 minutes a day with each assigned patient during the Evaluation Period. 5) Consult with the Team Leader or Assistant Team Leader every other day for general suggestions and directions.

[7]

6) Record a nurses note daily on each patient during Evaluation Period. These will primarily summarize B.B. and B.S. patient interaction during the day, and note any unusual observations.
7) By the end of the evaluation period (7th day), a progress note must be written in the nurses notes on each patient in Evaluation. (See attached

Admission to Ward	guideline). This note summarizes the B.B. or B.S. impressions of the patient and gives recommendation for disposition. 8) If B.B. or B.S. is scheduled to be off on the day of evaluation, write summary on his last working day before Evaluation and Disposition Meeting and place in Team Leader's basket.
R.N. or Delegate	1) Immediately following Daily Ward Management Meeting, pull charts on all patients in Evaluation Period for Team Leader's review.
Team Leader and Assistant Team Leader	1) Consult with B.B. or B.S. at least every other day during the Evaluation Period. 2) Review charts on all patients in Evaluation Period each day. 3) Insure that B.B. or B.S. completes Final Summary prior to Evaluation and Disposition Meeting. 4) Enter notation on check list when B.B. or B.S.'s final summary is written.

[8]

EVALUATION AND DISPOSITION MEETING

PURPOSE: To provide for specific planning for each patient based on the previous collection of available and essential information. Objectives are:

1) To assure compliance with the Mental Health Law in transfer from Evaluation to Treatment status.

2) To promptly identify those individuals who do not require hospitalization and to arrange for their release.

3) To promptly identify those patients who can best be treated in different settings, and to arrange for their transfer.

4) To identify those patients for whom treatment on the ward is both desirable and feasible.

5) To assure that each patient's presence on the ward is in keeping with specific, individual plans.

PARTICIPATING PERSONNEL: R.N., Physician, Big Brother or Sister, Team Leader, Assistant Team Leader, Psychologist, and Social Worker.

RESPONSIBILITY	ACTION
Team Leader & Assistant Leader	1) Insure that all information required for the meeting is in the chart at the end of the 6th working day—B.B. or B.S.'s progress note, nurses and doctors admission notes, mental examinations, assessments from involved adjunctive therapist report of family contact, and social history and psychological if ordered and available. 2) Notify R.N. of patients to be presented.
R.N. or Delegate	1) Insure that charts are pulled and patients available for meeting.
Physician and Team Leader and Assistant Team Leader	1) Review all available information on each patient. 2) Make a decision regarding disposition from the following alternatives for each patient:

	A. Assign to ward intensive treatment programs. B. Transfer within unit.

[9]

Physician and Team Leader Assistant Team Leader	2) E. Place on Convalescent Leave. F. Discharge. G. Hold for specified time and then release H. Specify further information to be obtained and defer decision to specified date.
Physician	1) Write orders necessary for above disposition.
Team Leader and Assistant Team Leader	1) Record disposition on Preliminary Evaluation Form. 2) Initiate action which will result in the disposition being carried out, and designate deadlines. 3) Schedule patient for team meeting if patient is assigned to ward intensive treatment program.
Big Brother and Sister	1) Check patient's chart to find recommended disposition. 2) If patient is assigned to ward intensive treatment, begin to function in treatment role of B.B. or B.S. 3) Begin preparation for presenting patient to team meeting.
R.N.	1) Insure that B.B. or B.S. performs above.
Team Leader	1) Initial and date disposition orders when disposition is carried out.

	2) Consult with B.B. or B.S. about treatment role with specific patients assigned to intensive treatment program.
Psychologist	1) Present psychological data and test results.
Social Worker	1) Present social, family and medical background.

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Admission to Ward

WARD AND TREATMENT TEAM MEETINGS

PURPOSE: To assure that all appropriate staff members are involved in these three major functions—program development and review, treatment and disposition of individual patients, and ward management. The first two functions are accomplished at the Weekly Team Meeting; the third is met by the Daily Ward Management Meeting. Objectives of the Ward Treatment Team as a whole are:

1) To insure that each staff member is aware of all ward objectives, and of his role in ward efforts to obtain these objectives.

2) To insure coordination of all ward-related functions.

3) To provide for participation by each staff member in the development and management of all ward-related activities.

4) To develop, implement, and review individual treatment plans.

5) To develop, modify, and coordinate ward treatment programs.

Admission to Ward

6) To provide for discussion and resolution of problems related to ward management, and to general and individual patient care.

PARTICIPATING PERSONNEL: All ward staff and, periodically, all personnel involved in ward activities participate in the Weekly Team Meeting. All ward staff participate in the Daily Ward Management Meeting.

RESPONSIBILITY	ACTION
Weekly Team Meetings (All Ward Staff) Major Function One (Monday—2:00 p.m.)	1) Meet weekly, 7-3, 3-11 shifts. 2) Discuss relevant general information, including general and specific aspects of ward programs and other items related to overall ward functioning, and make recommendations regarding identified problems. 3) Hear reports from adjunctive therapies related to general and individual patient care and make recommendations regarding identified problems. 4) Discuss the response of individual patients to treatment, and recommend appropriate changes in treatment plans.

	5) Discuss specific problems and needs of individual patients related to daily living, and make suggestions for correction.
Team Leader and Assistant Team Leader	1) Meet briefly with R.N. and Charge Attendant prior to team meeting to discuss material to be covered. 2) Initiate brief discussion about specific patient management

Admission to Ward

	problems, including walkouts and other privileges. 3) Notify staff of impending irregular events. 4) Following meeting, initiate or delegate any action arising from meeting.
R.N.	1) Insure staff attendance. 2) Announce daily census, previous day's patient movement, and patient movement scheduled for present day. 3) Inform treatment team of previous day's serious incident.
Charge Attendant	1) Announce individual staff assignments for the day.
All Staff	1) Briefly impart information necessary for the daily management of treatment for specific patient. 2) Discuss walkouts and other privileges for assigned patient.

[12]

Physician	1) Sign necessary orders for implementation of recommendations.
Team Leader and Assistant Team Leader	1) Insure implementation of recommendations approved by physician. Responsibility for this may be designated to other team members.
(All 7-3 Ward Staff & 3-11) Major Function Two: Treatment Planning (Mon.—8:30 & 3:30)	1) Formulate individual treatment plans for each patient assigned to intensive treatment programs at first 7-3 team meeting following disposition meeting. (See attached Treatment Plan Form.)

Admission to Ward

Physician	1) Write orders necessary for implementation of treatment plan.
R.N.	1) Insure attendance of all ward staff. 2) Insure preparation by all B.B. or B.S. presenting patients.
Big Brother or Big Sister	1) Pull Chart on patients he is presenting and have patients available. 2) Present background information necessary for treatment planning, reasons for hospitalization, precipitating factors, family situation, his general evaluation of the patient, etc. 3) Recommend treatment approaches.
Team Leader and Assistant Team Leader	1) Insure appropriate participation by all team members in treatment planning. 2) Complete Treatment Plan Form for each patient and insure inclusion in ward charts within two days after patient is presented for treatment planning. 3) Insure implementation of all treatment recommendations.
School, Recreation and Music	1) Add pertinent material
Daily Ward Management Meeting (All 7-3 ward staff & 3-11 shift) Major Function One	1) Meets 15-20 minutes daily at 8:30 a.m. and 3:15 p.m. regarding various aspects of ward management.

RELEASE PROCEDURES

Release may be initiated by the agency, facility or parent. If initiated by CGRH, notification will be given 30 days prior to release, so that pre-release conferences can be arranged with the parent or agency in which methods for handling the child can be discussed to insure continued success. Suggestions will be given concerning local resource agencies to assist in after-care.

In addition:

1. Medical information will be supplied upon request of the attending community physician.
2. School records and recommendations may be obtained by contacting: John Rawlins, Principal, School of Special Education, Central Georgia Human Resources Center, Milledgeville, Georgia.
3. Psychological information concerning recommendations for after-care will be provided for the community mental health facility responsible for after care. Additional information may be obtained by contacting J.T. Harris, RRL, Director, Medical Records Department, Central Georgia Regional Hospital, Milledgeville, Georgia.

Should release be initiated by either the admitting agency or parent, we ask that the request be made at least a week in advance to allow us time to make the necessary arrangements pertaining to medication and mandatory paperwork.

If the parent or agency is insistent upon release despite staff recommendations against such action, release Against Medical Advice will be arranged. In the event, the child will not be readmitted on a voluntary basis to CGRH.

RICHARD M. HARDEN/Commissioner
T.M.(JIM) PARHAM/Deputy Commissioner
GEORGIA DEPARTMENT OF HUMAN RESOURCES
CENTRAL GEORGIA REGIONAL HOSPITAL
on the Campus of
CENTRAL STATE HOSPITAL
Milledgeville, Georgia 31062

The following is a list of therapeutic activities sponspored and co-sponsored by the Music Therapy Department in the Children and Adolescent Unit (Past and Present). They provide structured environments for social interaction, environmental and interpersonal, as well as opportunities for stimulating certain appropriate behaviors needed by our individuals.

ON CAMPUS * = Not currently in Progress

Social Hour* Every other week
Square Dance* Every other week
Social Dance* Every other week
Choir—Once a week
Sunday Choir Performances—Approximately 8 times a year
Guitar Lessons/Group and Individual—Once a week
Drum Corps—Once a week
Piano Lessons—Once a week
Music Appreciation* Once a week
Creative Expression Groups—Twice a week
Various Recreation Activities (Pool, Ping Pong, Arts and Crafts, Volleyball, Football)—Unscheduled throughout year
Walks—Unscheduled throughout year
Trip to Circus—Once a year
Talent Show/Rehearsals, Performance/Film Show—Once a year
Birthday Parties—At appropriate times

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Christmas Party—Once a year
Valentines Party—Once a year
Halloween Party—Once a year
CHRISTMAS PAGEANT ACTIVITIES/Practice, Dress Rehearsal, Performance—rehearsals twice weekly a month before Performance
Groups—Music Exploration I and II, Music Crusaders I and II
Children's Choir—Once a week All Groups held once or twice/week
Individual Lessons, Guitar, Piano, Autoharp, Xylaphone, Flutophone, Ukelele—once a week
Special Drum Lessons, Central Music Therapy* Once a week
Children's Special Hour* Once a week

HOSPITAL ACTIVITIES ON CAMPUS Scheduled throughout year

These are activities just held in 1975!
Atlanta Symphony Concert
Warner Robbins Air Force Band
Barry College Concert
Lee High Singers
College Park High Concert
Atlanta Ballet
Organ Concert
Radcliffe Dancers
Youth Choir from Knoxville Tennessee

OFF CAMPUS

Reward Activities—to dinner at Central Kitchen, Breakfast, Lunch, Dinner, Shakey's, Dairy Queen Average 1 individual every two weeks; Choir—every week; Group—3 times a year

OFF CAMPUS (CON'T)

Overnight Visits* Once a month in past
Madrigal Dinners—Once a year
College Concerts—Whenever possible—In past 3 times a year
"10 Mile Walk" for Retarded Citizens—Once this year 1975
Six Flags Visit—Once a year
Ice Capades—Once a year
Baldwin County Fair—Once a year
Movies Hatcher Square—Periodically throughout year
Halloween Trick or Treat—Once a year
Holiday visits overnite*
Community Concerts at Georgia College—3 times a year
Programs and parties at various churches*3 times a year
Motor Cross in Macon*Once a year
Calloway Gardens*Once a year
Brown's Crossing*Once a year
Teen Club-varied home activities—crafts, cooking, socialization*Once a week
College volunteers/parties*
Swimming, fishing, picnicing—During Summer months
Special Olympics*Once a year
Jackson 5 Concerts*Once a year

[3]

RICHARD M. HARDEN/Commissioner
T.R.(JIM) PARHAM/Deputy Commissioner
GEORGIA DEPARTMENT OF HUMAN RESOURCES
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Milledgeville, Georgia 31062

September 26, 1975

MEMORANDUM

TO: Ward Personnel

FROM: Odilia Z. Gutierrez, M.D.

SUBJECT: Patient Care off Ward

In accordance with a memo dated 9-8-75 the following guidelines will be followed:

Children may be taken to the store and for walks in your role as big brother and big sister when you feel this is therapeutic.

A group of children may be taken for walks on the hospital grounds, to the pecan grove, playground, and outside the building when adequate supervision is provided. These groups going for a walk shall not exceed 5 children per attendant. If more than 5 go, two attendants have to go. For off campus trips or trips involving transportation in cars, an individual doctor's order will continue to be necessary.

Please continue the safeguard of making out two lists and frequently checking the patient during the outing and account for everyone upon returning to the ward. Continue to leave a list on the ward and take one with you.

Since the welfare of the children is our responsibility and priority, please observe every safeguard for their welfare.

/ag

[4]

SUGGESTED BIG BROTHER AND BIG SISTER RESPONSIBILITIES

The following outline is intended as a means of specifying the roles and responsibilities of Big Brothers and Big Sisters.

Some of the objectives for this program include:

1) Insuring that each patient receives personalized, individual attention by a member of the ward staff.

2) Keeping a written record of patient needs, progress, and treatment goals.

3) Involving all members of the ward staff as a vital, essential member of the treatment team.

Suggested Responsibilities

I. Spend at least a total of 30 minutes each week with an assigned patient.

a. Scheduling a consistent time on specific days will help you keep your commitment and let your patient know that there is a specific time set aside for his welfare. Barring emergencies and clinic appointments, etc., you should be able to meet with your assigned patients.

b. How you spend your time together is not as important as the fact that you are together. Nevertheless, there are several things you should look for while you are with your patients. The following points should be considered throughout your relationship with your patients—before you decide how to help him and while you are interacting with him.

1. Assess his self-help skills.
Does he help on the ward?

2. Evaluate his inter-personal relationships.
Does he initiate conversation? Does he answer questions coherently? Does he fear others? Is he aggressive, withdrawn, combative, or does he approach people only when he "needs" something?

3. Make observations on his thought processes.
Is he oriented to place and time, is he coherent, confused, does he know why he's here, does he have plans for his future?

4. Determine what activities and privileges might be therapeutic for him, what new programs might be initiated for his treatment, and what possible release plans might be appropriate.

c. Once you decide what he needs, you can begin to determine how to spend your time together. Suggested activities include:

[5]

1. Take him off the ward—outside, to the store, to the cafeteria, home with you, on special trips, etc.

2. Talk to him—talk about anything that might be of interest to him.

3. Play games with him, encourage him in his academic endeavors—find his difference and proceed from there.

4. If you feel your patient has a specific behavior problem you want to deal with, contact Mr. Coron or discuss the problem at the team meeting so that a specific program can be arranged for your patients.

II. Fill out a short behavior checklist on your patient each week. The behavior checklist will keep you aware of the changes in behavior that may not be noticed by other staff members. Your notes should include any

observations which might prove helpful to the team in assessing his condition.

III. Write a brief monthly summary on your patients' progress. This should include information from your weekly behavior checklists and any other observations concerning the patients. It should also include the long behavioral checklist.

/th

[1]

ADMISSION REVIEWS: Admissions of all Title XVIII and XIX (Medicare and Medicaid) patients and other patients as described elsewhere in this Plan shall be reviewed within one working day of admission except that, as determined by the Committee, cases of certain physicians or with certain diagnoses may be reviewed prior to admission. Using the approved Review Criteria generally available to the Medical Staff and other Clinical Staff, the Committee or its designated individuals will consider specific information in carrying out the review.

On the basis of the "admission review," using Committee approved Review Criteria, admissions will be classified as "necessary" or as "questionable." If the admission is considered "necessary" an initial "extended stay review date" will be assigned. If the admission is "questionable," further review procedures will be carried out, in the order felt most appropriate by the Committee Chairman.

After such further review, if hospitalization is felt to be "necessary" an "extended stay review date" will be assigned by the Committee. However, if after further review, the final determination of the Committee is that hospitalization is not necessary, the Committee shall give prompt oral and written notification to appropriate individuals and agencies. Such notice will state clearly that further stay is not considered necessary and therefore is not payable by the program involved.

The Utilization Review Committee will apply the following criteria in making recommendations applicable to justification for hospital admissions:

Each criteria is noted numerically with regard to intensity and is assigned a maximum rating, which is an expression of the relative importance of that criterion in favor of hospitalization.

(NOTE: A dividing line which makes hospitalization necessary should be established, most preferably after a test period of these particular criteria). . . . Suggestion, dividing line of 10 until such time test period has been completed.

CRITERIA FOR ADMISSION REGIONAL MENTAL HEALTH CENTER—CSH

Numerical Rating — Category

I. Present Mental Status

0—Good mental health.

1—Mildly impaired mental status as in mild neurosis, character, and personality disorders, or mild mental changes due to aging; e.g., anxiety behavior, physical agitation, pressured speech, manneristic behavior.

2—Moderately impaired mental status as in moderately severe neurosis or character disorders, organic brain syndromes of moderate severity, moderate impairment in reality testing, such as in ambulatory schizophrenics or reactive depressions; e.g., crying spells, sleep disturbances, eating disturbances, neglect of personal appearance, extreme social withdrawal, flat affect, psychomotor retardation.

3—Markedly impaired mental status with poor to tenuous contact with reality [2] as in organic brain syndromes, schizophrenic reactions, and moderate depressions; e.g., delusions, grandiosity, paranoid thinking, hallucinations, auditory, visual, tactile, olefactory, etc.

4—Extreme impairment of mental status, complete loss of contact with reality, severe psychotic reactions, regressed or agitated schizophrenics, severe manic or

depressive states, and severe toxic or organic brain syndromes.

II. Self Care Ability

Financial competence, food intake, personal and room cleanliness, autonomy of physical health, sphincter control, responsibility for family and possessions.

0—Able to care for self adequately.

1—Requires assistance in two or more of above areas.

2—Requires extensive care in regards to such things as; not taking medication, wandering away from home, uncontrolled epilepsy, neglect of personal hygiene.

III. Responsible Parties Available
(Relatives and/or friends)

0—Patient is independent, or responsible parties are permanently available.

1—Inadequate or marginal care supplied on temporary or involunatry basis.

2—No responsible parties available to a patient unable to care for himself.

IV. Patient's Effect on Environment
(Family or community)

0—No adverse effect.

1—Slight nuisance or burden.

2—Severe nuisance and annoyance requiring much time and energy to combat effect.

3—Intolerable to family and/or community.

V. Danger Potential
(to self and/or others)

0—Harmless to self and others.

1—Has threatened harm to self and others, or might be advertently dangerous. Threats of aggression, aggressive ideation.

2—More menacing threats of danger to self and others with history of "acting out."

3—Homicidal, suicidal, or destructive to the point of requiring restraint to protect self and society, attempted suicide, suicidal ideation.

VI. Alcohol and Drug Abuse

0—No adverse affect.

1—Currently intoxicated.

2—Danger of withdrawal complications.

3—Mixing medications and alcohol.

4—Acute withdrawal state.

[3]

VII. Administrative

1—Failure of outpatient or extended care management.

2—Referral from mental health agency or professional.

3—Inaccessability of outpatient psychiatric care.

4—Eligible veteran with a vacancy in Veteran's Unit.

5—Legal mandate for involuntary applicant.

The scale is seen to provide a scoring range from 1 to a maximum of 25 points. It has been developed to provide a systematic basis by which to make a decision to hospitalize a mental patient. It combines clinical psychiatric evaluation with community and social factors. It can be easily recognized that there is no single category which determines the need for hospitalization. Instead, there appears to be an interdependence of categories. It should be noted that ratings have validity only at the time of the evaluation and can change radically in brief periods. Individuals with relatively low ratings may have changes occur in their situation which may reflect in a higher rating at re-evaluation and may at such time require hospitalization. It should be noted that "community factors" such as the patient's danger potential and the community's or family's ability to care for and tolerate the patient are important factors in deciding the need for hospitalization. A rating falling on the dividing line or relatively near, either above or below may be necessarily referred for consultation at the discretion of the Committee Chairman.

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1. Mendel WM, Green G: The Therapeutic Management of Psychological Illness. New York, Basic Books, 1967.

2. Warner SL: Criteria for involuntary hospitalization of psychiatric patients in a public hospital. Mental Hygiene 45: 122-128, 1961.

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4. Goldblatt, PB, Brauer LD, Garrison W., et al: A chart-review check list for utilization review in a com-

munity mental health center. Hospital Community psychiatry 24: 753-756, 1973.

5. Flynn, Ph. D., Hulda R., Henisz, M.D., Jerry: Criteria for Psychiatric Hospitalization: Experience with a Checklist for Chart Review. AM. J. Psychiatry, 132:8: 847-850, August 1975.

6. Richman, M.D., Alex, Pinsker, M.D., Henry: Utilization Review of Psychiatric Inpatient Care. AM. J. Psychiatry 130:8, 900-903, August 1973.

7. Servilla, Scott, Harris, Shurling, Regional Mental Health Center Admission Evaluation Team, Central State Hospital: Criteria For Recommending Admission. August 1975.

[4]

UTILIZATION REVIEW COMMITTEE

6 May 1975

Conference Room, C&A Unit

The Utilization Review Committee of Central Georgia Regional Hospital met 6 May 1975 at 11:00 a.m. in the Children's Building Conference Room.

PRESENT: W. T. Smith, M.D., Chairman
L. Groves, Ph.D.
J. Perez, M.D.
D. Sans, M.D.

ABSENT: S. Aguilar, M.D.
C. Brookins, R.N.
W. Hertwig, ACSW
E. O. Melton, ACSW

The meeting was called to order at 11:00 a.m. by Dr. W. T. Smith, Chairman. The minutes of 1 April 1975 were approved as previously distributed.

NEW BUSINESS:

Eleven charts were reviewed and were found to generally indicate appropriate utilization in all aspects except one 13 year old boy (CSH# 205560) was ordered here by the Clayton County Court with no indications of an effort to get him transferred to the Atlanta Regional hospital, and another [redacted] (CSH# 172897) has been here over two and one-half years with a delay in getting proper release through the Family and Childrens Services.

The next meeting is to be held in the Veterans Unit.

WTS/bbh